

THE
MODERN HOSPITAL

VOLUME 45

JULY TO DECEMBER, INCLUSIVE

1935

THE MODERN HOSPITAL PUBLISHING CO., Inc.
CHICAGO

1935

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For July, 1935

Just in Passing—

COVER PAGE—Hospital of Jesus of Nazareth, Mexico City

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THE Hospital of Jesus of Nazareth, the first hospital in America, was established by the conqueror Don Hernán Cortés in the City of Mexico about 1527. Our cover design this month shows a view of the upper corridor facing the courtyard. Despite the fact that the rulers of Mexico are attempting to stamp out religion, this old institution is still run with government approval by Catholic Sisters, as it has been since its opening. The hospital was originally called the Immaculate Conception, being known by that name until about the year 1630 when a miraculous image of Jesus of Nazareth was won in a contest between five institutions. The name was then changed to the Hospital of Jesus of Nazareth. The building in which the hospital is situated is of colonial design and is well lighted and airy. The infirmaries form a transept and where they join the little chapel is located, which is convenient for those who wish to attend the religious ceremonies without having to leave their rooms. Patients are cared for without regard to race or creed, as provided by the founder. A considerable part of the funds bequeathed by Cortés are still held by the hospital.

ONE swallow does not make a summer. Although it is not our usual policy to present our readers with much material not written expressly for them, we make an exception to our practice in the small hospital symposium presented in this issue. Most of the articles in the symposium section (Pages 49 to 59, inclusive) are convention papers presented at the May meeting of the Tri-State Hospital Association held in Chicago. We think these discussions of public relations,

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accounting, standards for records, nursing and staff organization in the small hospital of sufficient interest to our readers to deviate slightly from our regular path. Don't you agree that this section makes a pleasant and noteworthy companion piece to our March portfolio of small hospital plans?

THE need for hospital morbidity statistics comparable in volume and accuracy to those for births and deaths is obvious, but a satisfactory method of assembling the data has not so far been worked out. Dr. Charles F. Bolduan of the department of health of New York City has recently revived a plan he made in 1913, and will describe it in the August issue showing how the mass of hospital morbidity data may be employed for statistical study with relative ease. The proposed system which is based on a "discharge certificate" does not impose on any hospital the adoption of a particular nomenclature of disease.

ALL of us occasionally wish for a yardstick with which to measure our depth of understanding of our jobs. Hospital superintendents who feel this urge may apply to themselves an acid test when the August MODERN HOSPITAL presents them with three sets of examination questions. These questions have been made available to us by the officials who recently conducted a series of civil service examinations for the positions of general medical superintendent and medical superintendent of a municipal hospital and superintendent of a home for dependents. If you wish to check yourself see what you can do with one set of questions in four hours, the time allotted to the candidates in the examinations referred to.

SURPLUS beds to a hospital are as reserve forces to an army. In both cases unnecessary reserve means extravagance but a reasonable reserve is essential to adequacy. Doctor Rankin will tell in the August issue wherein lies the margin of safety for the small rural hospital as compared with the large urban institution.

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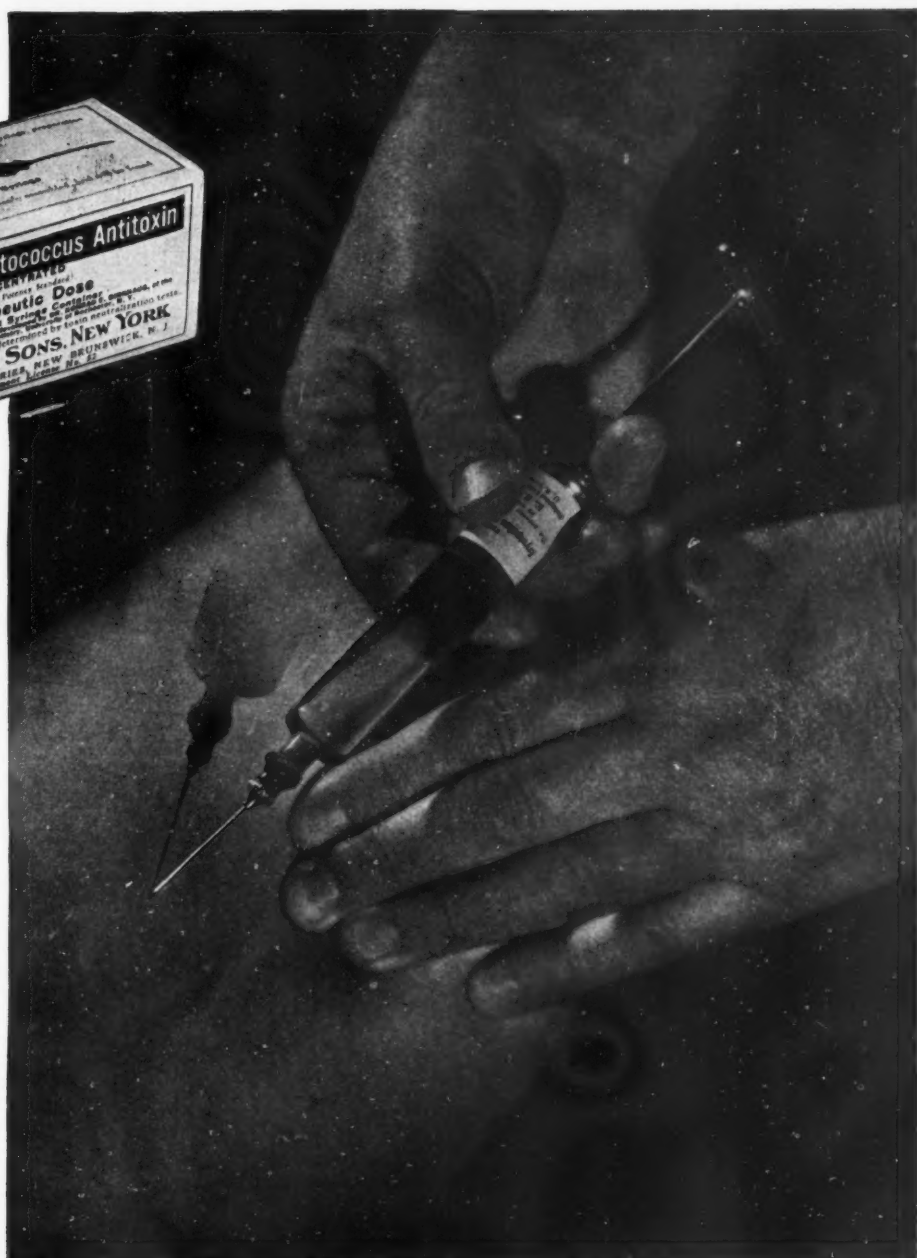
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We cordially invite you to visit the Squibb Exhibit at Booth Nos. 83 and 84 at the American Hospital Association Convention in the Municipal Auditorium, St. Louis, Mo., from September 30th to October 4th.

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his readers with subtlety! It now appears that a few persons thought we were opposing the convention. Nothing, of course, could be further from our thoughts. If we erred — which we are not yet ready to concede — we did so only by assuming a high I. Q. on the part of our readers.

SOME months ago Dr. R. C. Buerki declared in this magazine that hospital capital dollars were not giving their full service value. Next month the subject is to be considered from a different point of view by Dr. Nathan S. Davis III. Doctor Davis is well able to represent the medical profession as he is the third in a direct line to have achieved national prominence in medical affairs of this country.

IN a cooperative study of staff relationships in 1,332 voluntary hospitals in cities and towns of less than 250,000 population, the A. M. A. and the A. H. A. found that only 73 per cent of the hospitals had organized staffs and 66 per cent had courtesy staffs. The average organized staff in these hospitals consists of 26 physicians and the average courtesy staff of 20. Staff meetings are usually held monthly and over 50 per cent attendance was claimed by 71 per cent of the hospitals having staffs. About half the hospitals invite the courtesy men. On the average, 15.9 per cent of the hospital's patients are admitted by the courtesy staff. In all of these factors there were wide geographic variations.

FLASHES FROM THIS ISSUE:

"By telephoning the principal produce houses and meat dealers for anticipatory prices on fresh vegetables, fruits and meats, and consulting with the storekeeper as to staples and canned goods on hand, one can have a fairly clear picture of what may be expected for the week." *Page 94.*

"Group hospitalization has a community appeal and its sale to the public should be initiated by campaign methods." *Page 44.*

"At least one-third of the surgical patients in Chicago's general hospitals could be adequately served in properly managed and equipped institutions for convalescent care." *Page 56.*

"There are certain basic principles which must apply in the construction of the maternity department of a general hospital." *Page 82.*

THE MODERN HOSPITAL

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THE MODERN HOSPITAL

A Monthly Journal Devoted to the Construction, Equipment, Administration and Maintenance of Hospitals and Sanatoriums

VOL. 45

July, 1935

NUMBER 1

Training Hospital Executives

By F. G. CARTER, M. D.

Superintendent, Ancker Hospital, St. Paul, Minn.

MOST of us are hospital administrators through some trick of fate. We happened to be on the ground when opportunities opened up and we stumbled in for better or for worse. Few have entered the work properly prepared along predetermined lines after pursuing well mapped out courses of study and apprenticeship.

All of us have recognized the inherent weaknesses of this system and for years we have tried to do something about it. The American Hospital Association, the Catholic and Protestant Hospital Associations and the various state and regional associations through their conventions and the literature resulting therefrom have done much to improve the work of those already engaged in hospital administration. The standardization movement and the national and sectional meetings of the American College of Surgeons have contributed immeasurably to the advancement of administrative standards in hospitals. Various journals in the field have provided an excellent medium for the exchange of ideas. The institutes for hospital administrators, conducted by the American Hospital Association, and other well sponsored short courses have helped to equip hospital executives for their work. However, most of these aids to the hospital administrator come after he is already launched in his career.

Having secured a position, the newcomer to the

The hospital administrator is under the microscope! A committee is studying him from every angle, says Doctor Carter, who here shows up sharply the weaknesses of present methods of training superintendents and suggests remedies that may be applied

field often shuns hospital people for a time but eventually overcomes his timidity and suppresses his fear that somebody will discover his lack of preparation. At this point he usually becomes venturesome enough to take advantage of opportunities to perfect himself in the methods of his vocation. After a time he may become a good hospital executive but in the interim his hospital suffers because of the lack of a properly trained executive head. Many of us are products of such a school but that is not entirely to our discredit, nor is it an argument for continuing such methods. If we can find better ways of developing administrators all of us will benefit by the change.

In line with the thought that preparation should come first, committees of the American Hospital Association have studied carefully the problems

involved in training hospital executives, the various foundations have contributed liberally to the literature on the subject and several large universities have established courses to train prospective administrators. Most of these efforts have come to naught for reasons which are typified by the complaint made to me a few days ago by a capable young "administrator in training" who said:

"I have had four years of good training and experience and I can go on and get four years more of such training, but what shall I be confronted with at the end of that time? A position will open up and I shall apply for it, submitting credentials proving that I am adequately trained and competent to fill the position satisfactorily. Who will be selected for the position? That's easy. The person who has the inside track to the ear of an influential board member will get the appointment. He may be a board member whose business has gone wrong, he may be a poor but deserving relative of a board member, he may be anybody but a well trained hospital executive.

Finds Himself in a Blind Alley

"I tell you I am in a blind alley and I am getting out after four years of training for this complete disillusionment. So far as my own ambitions are concerned, I might better have spent four years of my time trying to find out how to maneuver myself into the 'pole' position in the race to the influential board member's ear. It is true that I wouldn't know anything about running a hospital, but I'd have the job I was seeking and I could learn how to administer the affairs of the hospital afterward at the expense of the hospital. With a little common sense, a bit of luck and the advantage of association with the hospital and hospital workers, I ought to be able to establish myself before a board which didn't have intelligence enough in the first place to select a competent executive, could possibly discover my shortcomings."

This young man had insight and his story emphasizes the fact that it is not enough that we find ways and means of training hospital executives. We must place them after they are trained and we must see to it that only properly trained persons are placed. Our other alternative is to cease the "ballyhoo" for proper training and resign ourselves to a perpetuation of administrative "accidents," polishing them up as best we can through the medium of conventions, short courses and hospital literature, after they enter the field.

Granting the validity of the criticisms outlined, what are we going to do about it?

In the first place we should come to some sort of agreement as to what a good hospital administrator is. We must clear up some of the haziness that

exists in regard to his activities, his qualifications and all the other attributes that might enter into his general make-up. What are his responsibilities, duties and relationships so far as the governing board of the hospital is concerned? What is his authority and what are his responsibilities within the hospital? What are his obligations to the hospital field, to organized medicine and to the community? What personal qualifications should he possess? The American College of Hospital Administrators in its first active year is undertaking such an analysis as its major objective for the year. A study committee is dissecting the hospital administrator from every angle. The report of this committee will be available in September at St. Louis.

When we are agreed on what a good hospital administrator is, it will be possible for us to set up standards by which administrators may be judged. In the past, governing boards of hospitals have experienced considerable difficulty in filling hospital administrative positions satisfactorily, and hospital administrators must assume their share of the blame for this condition, for the reason that they have not made available to governing boards generally recognized standards by which to measure the qualifications of candidates. These boards have known that they wanted to purchase a service, but they have been uncertain as to the qualifications they should look for in the individual appointed to render that service.

Once a standard covering the qualifications, duties, responsibilities and relationships of the hospital administrator has been established, the development and promotion of standards of education and training will follow in logical sequence, providing we find methods of forcing the recognition of these standards. As I have previously intimated, there will be no purpose in these efforts unless there is also developed an actual rather than a theoretical demand for the services of individuals who are willing to acquire proper training before undertaking the responsibilities involved in running hospitals.

Creating a Demand

The next step, then, after a standard is established will be to create a demand for the services of trained people. To do this it will be necessary to educate hospital trustees and the public to understand that the practice of hospital administration calls for special training and experience. It will also be necessary to convince them that only individuals having such training and experience are qualified for this work. Success or failure in our efforts to raise the standards of hospital administration will depend largely on how well we handle this step in the program.

Progress in this direction was recorded when the American College of Hospital Administrators was founded for the avowed purpose of improving hospital administration. The mere fact of its existence is in itself an impetus to the employment of qualified people. It should and will become the outstanding authority on all matters having to do with the hospital administrator. As it grows and develops, it will be asked to place its stamp of approval on candidates for administrative careers as well as administrative positions. It must be publicized and propagandized to these ends. It must concentrate on and persistently fight for the recognition of ability in the hospital administrative field. It has a great opportunity to become a force to be reckoned with in the hospital world. It should play a leading rôle in educating hospital trustees and the public to understand that the practice of hospital administration requires special training and experience.

Influence of A. C. of S.

The American College of Surgeons in its standardization program for hospitals has impressed upon all who have to do with hospitals the importance of its approval. It has indicated its willingness to make this approval contingent upon the qualifications and ability of the administrator in charge of the hospital and has recently withheld recognition from hospitals on these grounds. This action is bound to have a direct influence upon the selection of hospital administrators and should have much to do with forcing the recognition of the standards we are attempting to develop. What is more important, it is suggestive of the possibilities that might result if all of the national agencies interested in promoting the welfare of the sick and injured were bound together in a great federation working toward a common purpose, namely, the betterment of conditions having to do with handling the health problems of the nation.

These are examples of the type of effort that will be necessary to create a demand for the services of properly trained administrators. This lack of demand for trained people has been the stumbling block that has impeded all progress along these lines heretofore. If we can overcome this obstacle by the methods suggested or by other means, the advancement of the science of hospital management is assured.

Trends in the education of the hospital administrator then, may be summarized in a few words. Inadequacy and lack of uniformity in present methods of training are generally recognized. Improvements are coming through the general adoption and acceptance of standards which may be used for training as well as measuring the qualifications of candidates for positions. Finally, ways

and means of compelling the recognition of these standards are being elaborated. The most determined effort that has ever been made to train hospital executives properly, to place them after they are trained and to see that only those who are properly trained are placed, seems to be well on its way.

Now for a few comments on the probable effect of these trends on the hospital. Relations between trustees and administrators will be better understood with the result that each will adhere more strictly to his proper sphere of activity, thus making possible a more smoothly running organization. Incidentally, the educated trustee will appraise more quickly the work of the administrator and failure of the latter to produce results will not be tolerated for any length of time.

Although it is somewhat foreign to the subject under discussion, I cannot refrain from saying that it is interesting to speculate on the effect of the group hospitalization movement on the future of the hospital trustee. As this movement grows, it is conceivable that it will become a major factor in financing voluntary hospitals, and contributors to the scheme may rightly demand a voice in the government of such hospitals.

Within the hospital, the administrator will perfect his organization to the highest degree of efficiency. He will enlighten his employees as to the whys and wherefores of their work, and he will coordinate their efforts. Under the direction of administrators with somewhat standardized backgrounds, greater uniformity in the operation of all hospitals will ensue and this will make it possible to check the results of one against another with some assurance that the results are arrived at by the same methods.

Superintendent Must Keep Up to Date

The administrator will find it more than ever necessary to maintain an active interest in the work of the hospital field in general if he and his hospital are to keep up with the procession. He will belong to local, state and national associations because he will find that it is through these contacts that he keeps his knowledge of hospital progress up to date. Membership in these associations is not of itself sufficient. The administrator must participate in the programs, giving others the benefit of his experience, as he himself acquires benefit from hearing of the experience of others.

Standards for a competent administrator will demand that he give freely of his time to community interests. He will not only interpret the hospital to the community but will lend a helping hand wherever his qualities and experience are applicable and needed. He will serve best by cooperating to the fullest extent with organized medicine.

What Others Are Doing

Hospital Service Association Offers Use of Poster

A poster designed by Joseph Binder, Viennese artist, was used by the Hospital Service Association of St. Paul to call attention to its work on National Hospital Day, and has since been incorporated as a regular publicity feature of the organization.

Significant in design and modern in treatment, the poster, illustrated below, portrays a wounded head being supported by a hand, symbolizing the aid a hospital offers.

The association, of which E. A. Van Steenwyk is executive secretary, feels



that this poster could well be used by any community for its publicity purposes, and has announced its willingness to have additional copies printed at cost for other communities if they will reciprocate by making various sizes of the same poster and permitting the St. Paul group to purchase these at cost.

Heads and Supervisors Form Three Active Committees

The department heads and nursing supervisors of Sutter Hospital, Sacramento, Calif., have been organized into three committees by Superintendent R. D. Brisbane, one for entertainment and education of employees, another for publicity and public

relations, and the third to handle improvements and maintenance.

One of the responsibilities of the group on entertainment and education consists of the familiarizing of employees, and especially the supervisory staff, with the mechanical equipment in departments not their own.

In connection with this new movement, the hospital offered a prize of ten dollars for every original idea submitted by an employee that resulted in the improvement of service to guests. A number of valuable suggestions were the result, and several of them have already become part of the hospital routine.

Give and Take Between University and Hospital

Toledo Hospital, Toledo, Ohio, has effected an exchange arrangement with the University of Toledo which is considered of advantage to both organizations. The hospital's school of nursing is affiliated with the university and the student nurses receive regular college work there. In return the hospital provides for the regular students of the university competent health service at a minimum fee.

The school of nursing is also affiliated with a new nursery school which is linked with the university. Here the student nurses have their lectures in child psychology and their practice in the education of the preschool child.

"It seems reasonable to expect a wider sphere of activity for the hospital as a result of these community relationships," states George W. Wilson, superintendent.

Milk Separator Costs \$35, Saves \$200 a Month

To own a hand operated milk separator is one way to neutralize the effect of advanced milk prices, University Hospital, Augusta, Ga., has found. The hospital had been buying whole milk, skimmed milk, buttermilk and cream at a time when the price of milk advanced considerably and the price of cream almost doubled.

A separator was purchased at a cost of \$35 and paid for itself in five days. The hospital now buys whole milk and makes its skimmed milk and cream, and from the skimmed milk when

sour, its buttermilk. This is beaten in the kitchen mixer and a certain proportion of cream is added, making a better buttermilk than that previously purchased. The saving amounts to between \$200 and \$300 a month, according to Dr. John H. Snoke, superintendent.

The Intern as Guest of Honor

Festivities in honor of graduating nurses have become accepted practice in many hospitals, yet the intern who has successfully served his apprenticeship in hospital routine and is about to take his first important step into the professional world is not so frequently feted.

The Jewish Hospital of Philadelphia, however, each year pays its respects to those young men who are leaving the institution by giving a dinner in their honor. This also serves as an occasion for introducing the incoming group.

This dinner takes place in the hospital and is attended by the president of the board, certain of its members, the medical director and some of the doctors on the medical staff. The seating is so arranged that the newcomer can become acquainted with all those present. To make identification easier, each guest is provided with a seating plan which includes the names of all of those present. A few brief speeches comprise the program which is, however, for the most part extremely informal. In token of his services and as a souvenir of the months spent in the hospital, each intern receives a gift in the form of a book on medical practice and procedure.

Developing Home Talent

Many people engaged in hospital work have talents which they employ as avocations — a very essential outlet from the strain of their daily routine. Many times these talents find definite expression as applied to hospital procedure.

Much of the effect of the printed matter which emanates from the Newton Memorial Hospital, Newton, N. J., under the signature of Charlotte Janes Garrison, superintendent, is due to the introduction of amusing pencil sketches. The artist is a young man who fills the post of orderly on Miss Garrison's staff. He was discovered to possess the ability to express ideas in pencil and was immediately put to work.

Invitations issued to residents of the community in observance of National Hospital Day, for example, are likely to feature a sketch of the hospital and

other little scenes depicting hospital life. This year a woman was shown in bed gazing happily at the trim figure of a nurse entering with a tray well filled with dishes to whom the patient remarks, "The doctor says I am to have real food. Am I glad!"

Last Christmas special cards were prepared for each individual patient bearing his name and a sketch of himself. These were greatly treasured by the recipient as a souvenir of his stay in the hospital. Other messages sent out from the hospital during the year are similarly decorated.

The discovery of such latent talent in hospital employees helps the institution and develops in the individual new interest in his avocation as well as his vocation. It is suggested, therefore, that every hospital executive look about him for budding artists and writers whose talents may be enlisted in the interest of the hospital.

Patients Raise Funds for Community Building

About eleven years ago a group of women patients in a tuberculosis sanatorium dreamed of a chapel and community hall. At that time the only available gathering place was the crowded dining room which was disarranged every Sunday morning for religious services.

These women were sick and poor, but they had three pennies in their Sunshine Box, paid as fines by those among the twelve who had been cross or unjustly critical. The story of how those three pennies grew into the Ernest Cooper Community Building of the South Carolina Sanatorium, State Park, S. C., is a long record of unselfishness, sacrifice and hard work.

Patients formed a Tither's Club, and set aside one-tenth of all their money for the chapel fund. On birthdays each patient who could gave a penny for each year of his life. Tin-foil was saved and sold. Visitors and patients bought bricks for ten cents. An exchange put into operation by the patients for themselves raised over the period of years more than \$4,000 for the fund.

In May, 1933, the cornerstone of the building named for Doctor Cooper, superintendent of the sanatorium, was laid, and of the twelve women who had first visualized the chapel but four were still alive. The building was finished in July, but the cost of materials had exhausted the funds on hand, and a closed bank had taken \$5,000, so the patients had to face the fact that they had a building, completed, but empty. Three hundred seats had

to be provided and additional furnishings were necessary.

The general financial condition of the state of South Carolina prevented an appeal to the public for further aid, so in November a quiet personal campaign was begun by the patients among ex-patients, relatives of ex-patients and intimate friends for the purchase of seats at three dollars. These personal letters drew a prompt response, and by April, 1934, over



\$1,200 had been paid into the treasury. In September, 1934, the building was opened for use.

The chapel is cream colored and seats 300. Talking pictures are shown weekly and a public address system connects all infirmaries and broadcasts religious services, "talkies" and other programs to the headphones of bedridden patients. This is said to be the first installation of a sound projector machine built with a special panel to transmit the sound of a talking picture through headphones at the bedside of a patient. Behind the pulpit is a stage equipped with two dressing rooms and shut off from the pulpit during services by velours curtains.

Beneath the auditorium on the ground floor is a large sunlit library with hundreds of books, two guest rooms with a connecting bath, a post office, the office of the *SoCaPan Piper*, the sanatorium newspaper, and the San Shop, an outgrowth of the original exchange, probably the only sanatorium enterprise owned and operated by patients for patients.

Descriptive Pamphlet Published for Doctors' Use

When physicians on the staff of the Methodist Episcopal Hospital, Indianapolis, tell a patient that hospitalization will be necessary in his case, they present him with an informative pamphlet published by the hospital.

Compiled at the request of the staff, the pamphlet is designed to save the physician's time in presenting accurate

information regarding the institution and to reduce the mental hazard of patients who do not know what to expect when going to a hospital.

This eight-page pamphlet tells where the hospital is located and how to reach it, gives room rates, data on its children's department, states that the hospital is built on a foundation of science and service and not denominationalism, emphasizes the institution's homelike atmosphere, adding, in the description of its meal service, that if the patient is hungry and will say so, he will be amply supplied with extra food at no extra cost. The floor nursing service is outlined, the patient is told what he may bring with him, and emphasis is placed on the use of the hospital library.

John G. Benson, superintendent, says that the extent to which the pamphlet will be used remains to be seen, but he feels that the doctors will welcome its aid in shaping the mind and attitude of patients before their arrival at the hospital. Copies of the publication will be sent to anyone interested who will enclose postage with his request.

Probably you can think of one or more practical ways to save time or increase efficiency. The Modern Hospital will welcome your ideas to put before other hospitals



Modern Housing of Mental Patients

By WILLIAM A. WHITE, M.D. and MONIE SANGER

Superintendent and Assistant to the Superintendent, St. Elizabeth's Hospital, Washington, D. C.

SOME years ago it became evident that the population of St. Elizabeth's Hospital, Washington, D. C., was growing to such an extent that adequate provision for additional beds would have to be made. Thoughtful consideration of the situation made it clear that this provision would have to be so extensive that it would afford an excellent opportunity for a thoroughgoing revision of the scheme of classifying patients throughout the institution. The new men's receiving building, described here, must be considered in relation to this whole scheme in order that its several functions may be adequately understood and related to the complete hospital picture.

The first building to be erected in conformity with this new scheme, and which, in a sense, was the keystone of the arch, was the medical and surgical hospital building for acute somatic disease. This 200-bed building, which houses also the dispensary service and the nurses' training school, was opened for occupancy April 17, 1931.

The medical and surgical building is one of four buildings that occupy the north side of a quadran-

gle. The westernmost of the four is the laboratory. Then come the building for chronic somatic disease, the medical and surgical building, and the building for contagious disease. Opposite the medical and surgical building and occupying the southern border of the quadrangle is the new reception building for men, with 400 beds. On the east side of the quadrangle is being erected the new receiving building for women, which will accommodate 300 beds. All of these six buildings, which open and are entered upon the western border, are connected by corridors so that together they form, as it were, a unit. This eliminates the duplication of equipment, for a patient may be taken from one building to the other through the corridors for laboratory or other examinations.

This quadrangle constitutes the medical center of the hospital, in which all acute medicine, both somatic and psychic, is concentrated. There the best equipment and personnel are provided, the principle being that if any individual in the community of some seven thousand persons is injured or becomes acutely ill, either mentally or physi-

cally, he is transferred by ambulance to the medical and surgical building or to one of the receiving buildings especially provided for the treatment of the acutely mentally ill.

The men's receiving building was opened for the reception of patients on August 8, 1934. It is five stories in height, with basement or ground floor. From ground floor to the top of the attic floor slab it measures 72 feet 5 inches; it is 258 feet 4 inches long, and 188 feet 4 inches wide at the widest wing.

The construction is of reenforced concrete with red brick, and a Spanish tile roof. The main entrance is from a terrace. The entrance for patients is on the ground floor, arrangements having been made under a covered portico for ambulances.

As the patient enters the building a nurse carefully examines his admission papers, notes his name, religion, age, address of friend or relative and measures his height and weight. The patient is then disrobed, and all his clothing is listed. Valuables are carefully recorded, and note is made of anything dangerous in character. All property is marked after being checked, and placed in proper receptacles, the valuables in a vault and the other property in bags or in the clothes rooms. A careful examination is made for pediculosis; then the patient is examined for scars, bruises or traumatism of any nature. After this the patient is bathed and then partially dressed to await the arrival of the doctor.

Beds are provided in the admission suite when they are needed, also a litter and wheel chairs.

After the doctor's examination the patient is vaccinated and sent to the admission ward. The ward is selected according to the patient's needs, as designated by the physicians. The disturbed patients may be sent to the special treatment rooms in wards on the fourth floor.

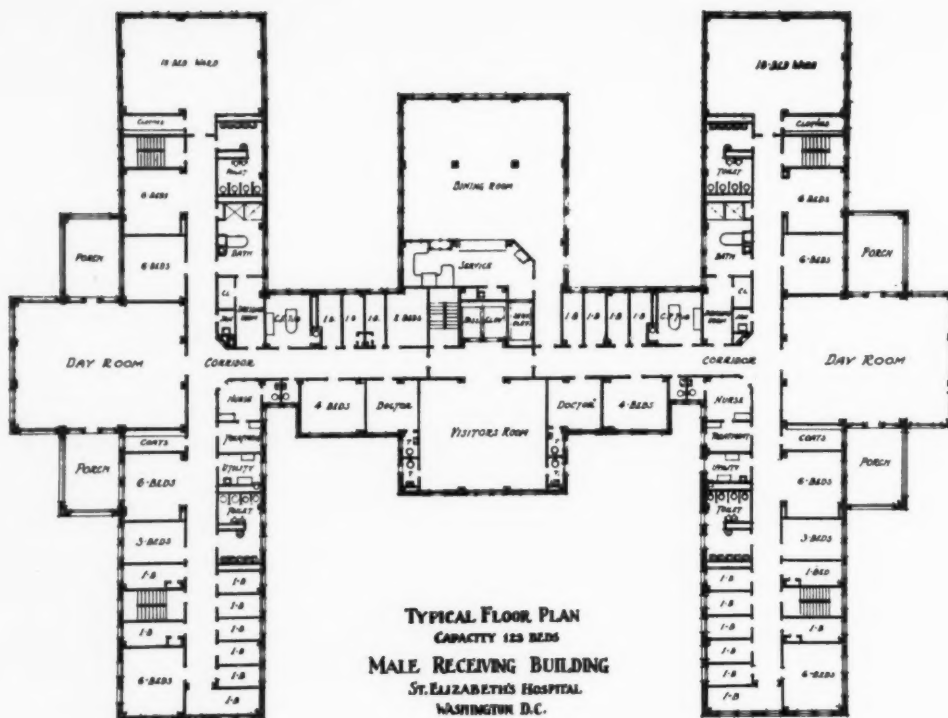
Connected with the reception suite is the vault where valuables taken from patients can be secured until they are transferred to the custody of the chief clerk of the hospital. Some effects of a semi-valuable nature are retained in the vault of the men's receiving building. Baggage rooms are provided for the storage of the patient's property. Steel bins, labeled alphabetically, are used to hold the baggage.

The ground floor contains locker rooms where each employee is given a separate locker for his clothes. On this floor there is also a modernly equipped barber shop containing two chairs, with all the paraphernalia needed in an up-to-date shop. A laundry chute from various wards terminates in a room here, and the laundry truck calls daily. There is a hydrotherapy department on the ground floor with steam cabinets, sitz baths, showers and pack tables, and several flow tubs. Occupational therapy is given on this floor. Included in this department is an electric printing press which turns out emergency work as required by the hospital. A large room is set aside for recreation and gymnastics.

There is a kitchen large enough to provide meals not only for the 400 patients in this building but



View of the men's receiving building of St. Elizabeth's Hospital, Washington, D. C., showing some of the many porches. The lobby is shown on the opposite page; its ceiling is two stories high.



All meals as far as possible are served in the cafeteria, shown below, and patients are permitted a selection in food service. One of the dormitories is shown here. It is provided with cubicles which give privacy and help to prevent overcrowding.

for the 300 additional patients in the women's receiving building. All meals as far as possible are served in cafeteria style, and patients are permitted a selection in food service. The kitchen is in the rear center of the ground floor. It is equipped as follows: two gas ranges; electric oven; kitchen table, with four bains-marie; meat broilers; deep fat fryers; vegetable steamers; various sizes of aluminum kettles; machines of various kinds for mixing, potato paring, chopping, can opening and juice extracting; coffee and tea urns; bread and kitchen cabinets, and other necessary kitchen equipment. There are also food cars and vacuum cars. In the store-room are metal bins and shelving. There are four cold storage rooms, one for meat, one for milk, one for fruit and vegetables and one for garbage. Included in this department are an office for the dietitian, a paring room and a trash room.

The main entrance goes to the first floor. It opens directly into a lobby, the ceiling of which is two stories high. There is a shield of the United States over the door; opposite, over the elevators, there is an electric clock. The walls are of travertine finish; the floor is of terrazzo. On one side of the lobby is the supervisor's and nurses' office; on the other side is the office of the chief medical officer. Immediately across the corridor from the lobby is the visitors' waiting room.



This architect's drawing shows the quadrangle which constitutes the medical center of the hospital. The women's receiving building is not yet completed. Of the six continuous treatment buildings surrounding a central kitchen and dining hall (at the upper right hand portion of the photograph) only two are completed.



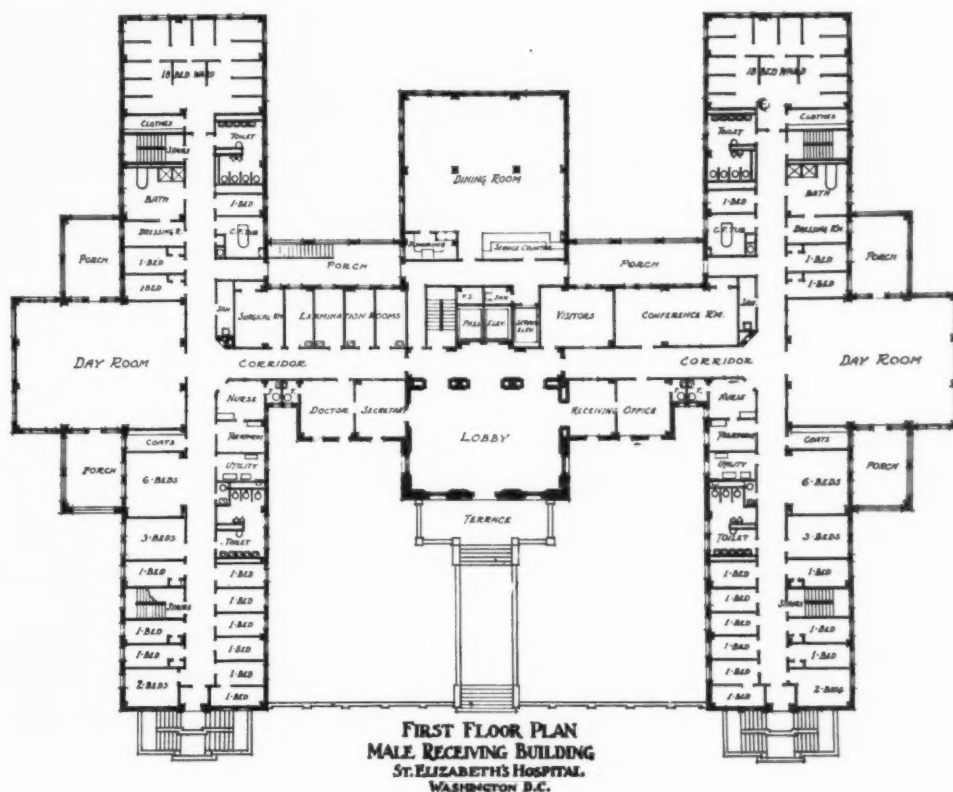
The building accommodates 400 beds. Two eighteen-bed dormitories are on the first floor, one on each ward. They have been provided with cubicles which give semiprivacy to each patient, and at the same time permit the nurse in charge to keep all the patients under observation. A typical ward, in addition to the eighteen-bed dormitory,

has eleven single rooms, one double room, and two six-bed dormitories.

Each single room is comfortably furnished with a bed, a dresser or chiffonier and a chair. The smaller dormitories have a bedside cabinet, a bed and a chair for each patient.

The south center wing of the first, second, third and fourth floors has been equipped for complete cafeteria units, with a steam table, a dishwashing room and dish cabinets, where all details in serving the meals are handled, with the exception of the preparation of food which is taken care of in the kitchen on the ground floor.

Each floor above the ground floor is divided into two wards. Each ward is provided with a nurses' office, with a treatment room adjoining. The nurses' office is at the end of the central corridor where it intersects the wing corridor. Each nurses' office is quipped with a medicine cabinet having a non-





The kitchen in the men's receiving building provides meals for 400 men as well as for 300 women patients. It is in the rear center of the ground floor.

corrodible alloy sink built into it. Adjacent to the nurses' and treatment room is a utility room, containing a slop sink, utensil sterilizer, bedpan sterilizer and utensil cabinet.

Each ward is provided with a continuous flow bathroom. A 20-inch laundry chute, leading to the soiled linen room on the ground floor, is accessible in each of the continuous flow bathrooms. Blanket warmers are mounted flush in the wall in the corridor immediately outside the continuous flow bathrooms. A few Gatch beds are distributed among the receiving wards for patients who may need them.

Each ward is also provided with a combined bath and shower room. There are two showers on the first, second, third and fourth floors, and one shower on the fifth floor. Two combined toilet and washrooms are provided for each ward on the first, second, third and fourth floors, and one is provided for each ward on the fifth floor.

Radios, with loudspeakers, are installed in each ward. These can be controlled from the central office. A microphone in the central office connected with this set permits direct communication with the wards for use in an emergency.

Large day rooms, with porches, are at the end of the center corridors of each ward. These contain card tables, magazines, periodicals and other means of entertainment.

Recessed drinking fountains have been provided at the point where the center corridor intersects the wing corridor in each ward, and also in each cafeteria. The water supplied to these fountains is cooled through a refrigeration unit.

The building is served by two passenger elevators and one service elevator, all in the center of the building. The two passenger elevators open on the central corridor at the point between the two wards on each floor. The service elevator opens on the kitchen and into the space immediately behind the serving counters of the cafeterias. It is used for the prompt transportation of food from the kitchen to the steam tables in each of the cafeterias.

The south center wing at the fifth floor has been designed for a heliotherapy deck, 52 by 46 feet.

Quarters for two interns or other physicians are on the fifth floor in the central section.

Ceilings of corridors and special treatment rooms throughout the building are equipped with sound deadening material. The floors of rooms and corridors throughout the building are covered with $\frac{3}{16}$ -inch battleship linoleum. Base and border throughout the building are of terrazzo. Bathrooms and toilets have floors and wainscot of tile.

The windows are of a special design, in order to give the maximum of protection and to relieve the building of any possible resemblance to a penal institution.

The furniture has been carefully selected, different colors being used on each floor. The furniture for the disturbed class of patients is of oak, the beds being white. This is changed to walnut for a patient who requires less care and is quieter. On the lower floor, for the paroled class of patients, the furniture is mahogany. Thus, as the patient improves, he is changed from ward to ward, with a different type of furniture, reacting to the

changed conditions. The color of the furniture in the admission suite, hydrotherapy room, employees' locker rooms and storage rooms is olive green.

The various floors have been designed for bed capacity as follows: first floor, 82 beds; second floor, 116 beds; third floor, 123 beds; fourth floor, 51 beds; fifth floor, 28 beds, or a total of 400 beds.

Doctor Noyes Evaluates the Plan

Dr. Arthur P. Noyes, superintendent of the State Hospital for Mental Diseases, Howard, R. I., contributes the following comments on St. Elizabeth's new building:

"This new reception building for men at St. Elizabeth's Hospital reflects in concrete form the gratifyingly increasing emphasis upon the medical and therapeutic functions of psychiatric institutions. In nearly all features essential to a large psychiatric receiving service this latest product of Doctor White's long career, distinguished both for its psychiatric and for its progressive administrative contributions, may well serve as a model.

"With surprising frequency the construction arrangements of psychiatric reception buildings require that patients be received at the general entrance lobby from which, perhaps after varying admittance procedures in an office opening from it, they pass to a ward for a bath and the completion of admission routine.

"The separately located admission suite with its convenient arrangement and adequate facilities constitutes a conspicuously desirable feature of this building. The main lobby, so often in psychiatric buildings a mere cramped hall or vestibule except in the administration building, possesses a pleasing spaciousness. The first floor seems to lend itself particularly well to the housing of ground-parole patients who may enter at the north end of each ward without passing through the lobby, and on entering the dining room may avoid the main corridors by using the south porches.

"The nurses' office on each ward is advantageously placed and easily permits necessary observation of day room and corridors. The day rooms, centrally placed in reference to their respective wards, enjoy a maximum of light and air. The porches opening from these day rooms are to be commended, although perhaps both porches and day rooms are somewhat small for wards occupied by disturbed patients. The provision of cubicles in the dormitories is especially praiseworthy. The bedside cabinet will be greatly appreciated by the patient. In some institutions individual lockers by the bedside are successfully employed and afford more room for clothing and personal effects.

"Among minor criticisms that might be made is the arrangement providing that toilets and washrooms be combined. Toilet, lavatory, bathroom, dressing room and clothes room might be arranged in a continuous, connected suite in one wing of a ward. The large ward capacity requires that toilet and lavatory facilities be duplicated in the contralateral wing but their combination there is similarly undesirable.

"The equipment of a ward with a single continuous flow tub would seem to increase the cost of ward operation unnecessarily. These tubs might be restricted to wards for disturbed patients and there increased in number, or such tubs might be confined to the hydrotherapeutic suite in the basement. The article does not contain a floor plan of this hydrotherapeutic suite but personal inspection of it disclosed that it consists of a large open room in which are installed a considerable number of continuous flow tubs and pack tables. The present and seemingly desirable tendency is to provide some degree of segregation of patients in such suites so that a patient may not be stimulated or disturbed by his neighbor.

"Although on searching for them one may discover a few points that may in the practical operation of the building prove to be minor imperfections, yet in this building the patient will find himself in surroundings skillfully designed for both comfort and recovery while the physician and nurse will enjoy ample and serviceable facilities."

Hospital School Education

In a large number of hospitals the school phase of hospital education is limited to ambulatory patients and convalescents. This results in the neglect of acute cases except for such limited periods of bedside visiting by teachers as a limited staff will permit, it is pointed out by L. W. Keeler writing in the *School of Education Bulletin* of the University of Michigan. Excerpts from the article follow:

If adequate space were provided within the various units of the hospital a large number of individuals from the acute wards could be assembled in this central space. Elevator service should make possible this assembly of patients who could be moved without danger. Patients on beds, in wheel chairs and in casts would feel the inspiration of working in groups having a common objective. Such a procedure would ensure more lengthy contacts between teachers and pupils and a considerable reduction in the cost of teaching personnel.

Books and equipment could be much better handled if centralized in this fashion and could be more carefully preserved for continued use. Such an arrangement would also permit more flexible treatment of school projects. It is evident that a hospital curriculum cannot embrace the traditional procedure of the public school. It must be based on the principles of special education and adapted to the needs of hospitalized persons, and this cannot be done by teachers who flit from bedside to bedside, giving a few minutes to each patient.

Someone Has Asked—

What Is Preferable as a Wall Covering?

In some instances a material of the nature and consistency of oilcloth is employed to cover walls instead of the conventional gloss or dull paint. The makers of these wall coverings contend that they are cheaper because of their lasting qualities, which eliminate frequently applied coats of paint.

There are some locations in the hospital where such a covering is most satisfactory. On the other hand, when walls are bruised by stretchers or other movable equipment and a waterproof covering is torn, a neat repair is rather difficult.

Unless a hospital is able to stand the first expense for the purchase of such coverings and to have at hand sufficiently skilled labor to repair them properly when they are worn, the advantage of this type of article over the painted surface becomes doubtful. Certainly, a worn wall covering of this type or one which is clumsily repaired presents an unattractive and insanitary appearance.

Is It Ethical for a Hospital to Engage Nurse Anesthetists?

A worried superintendent in an Eastern urban hospital asks this question. Members of the staff of his institution insist that the nurse anesthetist is a dangerous competitor of the doctor and that the hospital has no right to profit by her presence in the institution. They also claim that physicians should be permitted to give anesthetics to their patients or to patients sent to the hospital by colleagues for operation.

There are in the hospitals in this country many splendid, highly trained nurse anesthetists who take their work seriously and who administer anesthetics far more skillfully than does the average physician. This is true because relatively few physicians specialize in anesthesia and because medical schools have not stressed this specialty in undergraduate or postgraduate courses. Many doctors look upon the administration of an anesthetic as a simple and relatively harmless procedure. Some are convinced that special training is necessary and that the period of anesthesia is one of danger to the life of the patient.

The average intern is much bored

with his anesthesia service and exposes himself to this experience only because state boards have ruled that this must be done. The doctor is often more interested in what the surgeon is doing than in the dimension of the patient's pupils, the color of his lips or the nature of his respiration. The nurse anesthetist knows that her professional career depends upon avoiding accidents.

There is another angle to the question. It is a common practice in some hospitals for the physician who refers a case to the surgeon to be permitted to give the anesthetic and to charge therefor a fee which is usually out of proportion to the value of the services rendered. This is an adroit method of fee splitting or of providing a *quid pro quo* for referring the case.

In answer to the question asked, it is perfectly ethical for the hospital to guard the welfare of its patients by engaging a skilled nurse anesthetist. Whether the results of her work at the end of the year are financially profitable is a matter that concerns the hospital only. Until medical schools provide proper instruction and physicians take seriously the matter of administering anesthetics, the nurse anesthetist will no doubt find ample opportunity for the exercise of her abilities.

How Should Summer Vacations Be Covered?

Vacations are not an unmixed blessing. From the hospital's standpoint they are likely, temporarily, to lower efficiency and add expense. From the worker's standpoint they are absolutely essential, and the refreshment thus received must in the end benefit the hospital.

When a department head is vacationing, the assistant may carry on at no additional expense to the institution. In the school for nurses, vacation substitutes for floor supervisors are often necessary. In dietetic and laboratory departments, the operating rooms and other locations where relief is not available from within, tempo-

rary appointments must be made at the expense of the hospital.

Vacations, however, should be given at a time and in a manner which will entail the least expenditure of funds. A faithful worker deserves rest if she is long to remain faithful. Even though the hospital is put to added expense to carry on the work during the summer months, vacations should not be unduly curtailed nor should efficient personnel members be made to feel they are being granted an unmerited perquisite.

How Can Records Be Kept in a Hospital That Has No Interns?

There are hundreds of small hospitals which, because of their size and available clinical material, are not able to secure interns. Here the duties usually assigned to these young physicians are carried on by staff members. In such hospitals the records of patients are often hardly of sufficient worth to justify their preservation and filing. The superintendent of one of these institutions asks the above question.

It is almost impossible for a busy practitioner to spare the time necessary to compile records. Moreover, many physicians are not able, even if inclined, to write a history which can compare with that of a recent graduate in medicine. No superintendent is justified in permitting careless record taking, since there exists a direct proportion between the type of scientific work performed and the character of the clinical chart.

In the small hospital the board of directors might engage a skilled stenographer to accompany physicians on their rounds and record the results of their examinations. The chief should be responsible for the inscription of daily notes; the clerk may be assigned the copying of laboratory reports, and a committee of the staff could be formed to visé clinical charts before they are filed. In this manner even the small hospital may be able to perform good record work.

Good histories do not usually follow the use of printed forms of the "yes" and "no" type. Blank history sheets with the installation of a system similar to the above should prove more efficient. The MODERN HOSPITAL does not believe that the size of an institution or the presence or absence of interns justifies shoddy records.

If you have any questions to ask, the Editor will be glad to discuss them in a forthcoming issue

A Small Hospital Offers A Program of Public Relations

By MACIE N. KNAPP
Superintendent, Brokaw Hospital, Normal, Ill.

ANY program of public education in reference to hospitals must be backed by service, for the patient who is restored to health and strength and leaves the hospital satisfied is the best recommendation and advertisement any hospital can have. Another essential is the co-operation of the staff, the daily paper and all organizations and individuals associated with the institution. Regardless of its size or location, any hospital can successfully carry out an educational program on this basis.

At Brokaw Hospital we have an active women's service league whose president is both public-spirited and civic minded, and last fall we decided to carry on our public education program through this organization. The program that the members developed has been active and, we feel, decidedly worth while.

On several Sunday afternoons fifteen-minute talks supplied by the American Hospital Association were broadcast by the league. A former patient, the proprietor of one of our largest stores, offered his new tea room for a radio tea, from which musical numbers and a spirited talk by the president were broadcast. Silver teas, held in surrounding towns, were well attended. Our annual cradle tea was held as usual at the spacious home of former Governor Fifer. The quaint antique cradle, placed in the entrance hall for gifts of baby garments, is always piled high with packages.

How the Nurses' School Helps

The school for nurses has been conducting a monthly lecture course, which included talks on the arrangement of flowers, by a local florist; on general phases of education, by the president of the Illinois Parent-Teacher Association; on the "coal tree," by the chief combustion engineer of the Alton Railroad; on personal experiences in Turkey, by the hospital superintendent, and on legislation, by a former state senator.

The capping exercise, which is always so beautiful, was made quite an affair, and in spite of the early morning hour several guests as well as

*Radio talks, teas, clinics, lectures—
all have their part in the program of
public education conducted by Bro-
kaw Hospital. But more important
than any of these is the underlying
principle of thoughtful service, based
upon small considerate deeds, that
produce grateful and loyal patients*

a local photographer were among those present.

We have held variety clinics for the junior women's club, the home economics class of Illinois Wesleyan University and the business and professional women's club. The routine has been the same for each group, bath in bed, bathing baby, x-ray films, laboratory, sterilization of operating room supplies and teaching models in the classroom. These were all request clinics and created a great deal of interest.

Several of our student nurses have joined the junior women's club and are entering into the activities of this organization.

Two troops of girl scouts, forty in each troop, marched from their school in full scout uniform to the hospital, where they were taken on a tour of the institution, shown films which tell the story of broken bones from automobile and other accidents, given a talk on hospital care in accident cases and brief instructions in first aid. I am told by their leader that this is one of the big events of the scout year.

The crowning event of the year was the public relations dinner in February when Robert Jolly, president of the American Hospital Association, was our guest speaker. This was well attended and attracted several hospital executives from Chicago and other cities. Many of those present were former patients. Prominent citizens since then have told me that our only mistake in planning this meeting was that we did not engage

a dining room which seats a thousand people. No speaker on any subject has ever been better received.

Just last week we held a rather unusual trustees' meeting. We invited our trustees and all the ministers in town to a dinner meeting at one of the churches. There were brief talks by the president of the service league, the superintendent of nurses, the maternity supervisor, a laboratory technician, one of the senior students taking the five-year course, and by the superintendent of the hospital. All forms that are given to patients were placed at each plate. We had some of our equipment there—the electrocardiograph, an electric breast pump, a metabolism machine, a gas and oxygen machine and a shadow box to show a series of interesting x-ray films. If the discussion which went on was any indication, this was a most interesting trustees' meeting.

During the past four years the limitation of financial resources has been a great handicap. A public education program is not designed or carried on to collect accounts, but there is no doubt in my mind that any hospital that has made a place for itself in its community and continues to hold that place, will succeed. An active program costs money, but I assure you it is money well spent.

What the Superintendent Can Do

I believe it is the duty of hospital executives to take an active interest in other community organizations. I serve on the boards of the Y. W. C. A. and the business and professional women's club. I belong to the council of social agencies, a literary club and the Illinois league of women voters, and I try to take an active part in my own church. The superintendent of nurses and I have prepared and presented papers before groups on subjects ranging from "Infant Feeding" to "Who Wants War?"

We try to attend all community affairs—church suppers or whatever happens to present itself. It is true that these outside activities all take time and effort, and schedules have to be rearranged, but I feel that it is worth while and good for us and for the hospital.

Our educational program starts as soon as the patient is admitted. Probably no other phase of hospital work can be more productive of friendliness and good will than the act of admission. To the majority of patients it is an occasion filled with forebodings about the future. If the admitting clerk is sympathetic it will help both the patient and the hospital, for we all know that psychologic factors are important.

A folder which tells of the room rate and rules

of the institution carries a friendly greeting which reads, "Please feel that all of us here are your friends and that we stand ready to help you with any thing, at any time." This is followed later by several other cards, one for the first tray, one for the new mother, one following operation. A message is stamped on the patients' morning mail saying, "Good Morning, we wish you a pleasant day," and also on the daily paper, which is presented with our compliments to the private room patients. These mean so much and cost so little.

Each week a questionnaire from the dietary department asks for suggestions, and each patient is asked to fill out a folder before he leaves which asks: "Are you leaving the hospital satisfied?" "Have you any suggestions that will improve our service to others?" The two forms are taken to each directors' meeting where they are routinely read and they are filed as a permanent part of the patient's record. There is a great deal of interest created among the nursing staff and employees through these forms and there is no doubt but that it is good psychology to have patients feel that we are interested in their opinions.

The question has arisen as to whether such a program is worth the endless time and effort that have to be expended to carry it on. Personally I believe it is, but may I emphasize the fact that any program is worthless unless the hospital holds its place in the community by meeting all community obligations promptly and taking the best possible care of its patients.

Hospital Terms and What They Signify

What is the bed capacity of a hospital? Should space that was originally planned for patients' beds but has since been converted for use as nurses' dormitories, or laboratories or for other purposes be counted in the bed capacity? On the other hand, if conditions are crowded and beds are placed in corridors and crowded into wards, should the bed capacity of the institution be considered to have increased?

A definition of bed capacity given in the thirteenth edition of *The HOSPITAL YEARBOOK* gives a guide by which to answer these questions. The definition is: "The total number of beds for patients that are occupied or immediately available for occupancy (a) within a brief time (such as one week or less) and (b) without substantial outlay for additional equipment or building changes. To be included in the bed capacity beds should have the space and equipment customary in the hospital. Thus beds placed in halls and closets, would not be included in the bed capacity even though occupied."

The "Glossary of Hospital Terms" in *The YEARBOOK* contains definitions of statistical and accounting terms, clinical and administrative terms, and heating and ventilating terms of value to hospital administrators.

The Small Hospital Asks for Better Standards for Records

By EDNA H. NELSON

Superintendent, Ryburn Memorial Hospital, Ottawa, Ill.

THE increase in the number of hospital patients during the past quarter of a century has resulted in a new relationship between the hospital, the patient and the physician, which has brought about the necessity for complete medical records and their standardization. While large and medium-sized hospitals have found it comparatively easy to meet both the minimum and maximum requirements, as set forth by the American College of Surgeons, small hospitals have encountered some difficulty. Because of the value and importance of medical records the problem is a significant one.

One of the requirements of the minimum standard is "that accurate and complete case records be written for all patients and filed in an accessible manner in the hospital . . . a complete case record being one which, except in an emergency, includes the personal history; the physical examination with clinical pathologic and x-ray findings when indicated; the working diagnosis; the treatment, medical and surgical; the medical progress; the condition on discharge, and in case of death, the autopsy findings when available."

Not enough consideration has been given to the matter of medical records in a small hospital. Records such as may be kept in a large institution are too complicated for the small hospital which has no interns and few, if any, clerks, and where most of the history must be written in longhand by the attending physician or the part-time librarian. An efficient system, especially adapted to the small

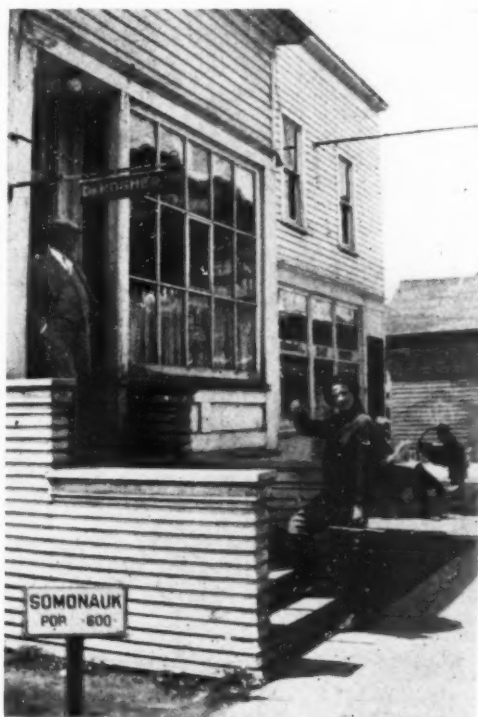
Isn't it about time, asks the small hospital, that some cognizance was taken regarding the differences of large and small hospitals in this matter of medical case records?

hospital, by which a history containing all the data necessary to conform to the rules and regulations of the American College of Surgeons may be included with as little repetition as possible, is needed. Often, under our present system, there will be several sheets containing duplicate facts and a repetition of the working and final diagnosis which require the doctor's signature. We have found that the average doctor does not think it necessary to give much of his time to writing records he frequently thinks are superfluous. To many doctors keeping their records up to date is a tedious task, and the record librarian

finds it difficult to enlist their services. Many of the older staff members, graduates in medicine long before such a record system was established, do not know how to write them satisfactorily and completely. This further complicates the librarian's work.

A number of doctors keep complete records of their patients, including histories and physical examinations, in their own offices and rebel at spending their valuable time in rewriting them. We have found that if we establish contacts with physicians' office girls our records can be made more complete.

In a small hospital with no interns the record room should be near the entrance of the hospital, for doctors



This librarian went thirty miles to visit a doctor's office and complete a case record.

need constant encouragement and sometimes a little gentle prodding.

The record department must have the wholehearted support of the medical staff. We have difficulty, with our visiting staff, in getting charts completed and filed. Frequently a long time elapses between these physicians' visits to the hospital. Consequently, if the chart does not happen to be signed immediately, and often this is impossible, the records become old, the doctor has difficulty in remembering the facts of the case and unsatisfactory records result. If the small hospital could rule that a doctor could not discharge a patient before the medical record was satisfactorily complete, the work of the librarian would be much easier. Our librarian has gone thirty-five miles to visit the offices of doctors who failed to give this matter their attention when their patients were in the hospital, and who later did not find time to answer letters asking for information that would make it possible for the librarian to complete the record.

Enlisting the Nurses' Help

Every effort should be made by the hospital to help the physician secure the history and record it. The securing and writing of the record must be done under the direct supervision of the doctor who is attending the patient. In a small hospital there are certain parts of the history, the sociologic data, the family history and the personal history, which may be obtained by others trained in the work. If the hospital does not have enough record clerks, one of the graduate nurses on duty might receive instruction in the record department. She could help the doctor with examinations, take his dictation and record his findings. If every nurse could know a little something about record work it would help materially. Too often a physician makes an examination or notes changes in the condition of a patient and nothing is recorded on the progress notes because the record clerk, who cannot possibly be with each doctor all the time, is not present. In small hospitals where record clerks may have other duties, they are not always on the floor during a doctor's visit.

Student Could Learn Much in a Month

The small hospital needs the cooperation of its nurses in compiling medical records. The head nurse on the floor is responsible for the care of records and the recording of all acts performed by the nurses. This is an important and delicate function, as this record may at times have to show things that reveal delinquencies on the part of nurses and others. The head nurse also has to

call attention to points physicians and technicians have failed to record. Because the nurse is not acquainted with the terminology used in the record department, she often accepts from doctors such working diagnoses as "uncontrollable nausea," "hemorrhage" and "paralysis." It seems to me that it would be well to make service in the record room a part of the school curriculum. The student might serve one month in this department and in this way learn how to keep a patient's record. This type of training would help her realize the importance of good recording.

Incomplete Histories Sometimes Filed

When the record librarian has other duties to perform, patients are occasionally allowed to leave the hospital without having their histories taken. Because social and economic changes have altered the relationship of physician to patient, the doctor may no longer know his patient intimately enough to remember heredity, past illnesses and idiosyncracies, with the result that case histories on these patients are filed incomplete.

Often in the small hospital there may be two or three persons doing part-time work in the record room. Complications may arise when one does not know what the others have done. The personal history and physical examination of the patient are supposed to be taken at admittance. When patients are admitted after the record librarian has gone off duty, this is impossible. If patients remain only one or two days in the hospital and if the clerk is busy with other duties during this time there is a possibility that no history will be taken. Usually the record librarian is not qualified to record a complete physical examination and if there are no interns this record often is not filled out until the doctor has leisure. When this occurs some facts may be forgotten or the record written too hurriedly to be complete or valuable for future reference.

Progress Has Been Made

If a patient dies the chart is seldom complete with autopsy findings. In small communities it is difficult to get families to consent to an autopsy. Even though the undertaker may encourage it, there seems to be more prejudice and fear on the part of the families than is customary in larger centers.

Despite the fact that we feel record departments in small hospitals are not, as yet, wholly efficient, when we look up old records and find such diagnoses as "laparotomy" and "sick stomach," we feel that we have made a great deal of progress towards our ultimate goal of perfection in medical records.

In a Small Hospital— Organizing the Medical Staff

THE supervision of a small hospital brings with it a challenge that similar work in a large hospital cannot possibly bring. Management of the small town hospital demands an acquaintance with city officials, doctors, patients and their families. It necessitates qualities of tactfulness and patience which the supervisor of a large hospital seldom needs to develop to an equal extent.

In a small hospital, where every inch of space must be utilized and doctors are few, the problem of organizing a medical staff is one that taxes the ingenuity of any hospital executive. Stringent rules must be laid down and followed. Unless a certain routine is exacted there is confusion.

Our first step was to become acquainted with our doctors. In this small community 97 per cent of them are general practitioners. Since ours is a municipal institution, we were beset with difficulties at once because, while all the doctors in the community had access to the hospital, they had no direct interest in the institution other than to use it as a convenient "nursing home" to which critically ill patients could be brought.

An invitation to dinner was our second step. Since the board of directors is the connecting link between the superintendent and the medical staff it was essential that the members of the board be invited to this dinner which was given by the hospital for all its doctors.

This board of directors and these physicians had not been properly educated to the advantages of an organized medical staff. The superintendent, therefore, had to explain to this group just what an efficient organization would mean to them, to the community, to the hospital and to the patients, and to inform each doctor and board member that unless he was willing to cooperate and fulfill his duties, he would be the cause of the institution's not being properly staffed.

With the mechanism of organization started, the surprising interest and cooperation from the board of directors and the doctors were gratifying. Staff officers and a committee to formulate by-laws, rules and regulations, were appointed and the day and hour was selected for regular meetings at this first dinner meeting.

By AGNES HATCH

Superintendent, De Kalb Public Hospital, De Kalb, Ill.

As the superintendent of a small hospital must assume the greatest share of responsibility in the maintenance of a well organized staff, it is imperative that she be discreet and alert to prevent the dominance of one or more doctors. At her suggestion, committees of importance can be established. With us, these were an executive committee, a grievance committee and a public relations committee.

Each doctor should be active in some official capacity in order to keep up his interest and good will. You will find that some of your doctors are interested in a particular phase of medicine such as x-ray, pathology or obstetrics. Let these doctors assume the responsibility for the development and management of these services.

The organization of the medical staff in the hospital which I represent was by no means quickly accomplished. It has taken time and patience. There are always little problems which arise and may cause confusion in the organization unless the superintendent is ever watchful. She must develop an interesting and constructive program for each meeting and be constantly on the alert to notice any unethical procedures. It is her duty to see that good clinical records are kept.

One advantage we have in our hospital is the absence of fee splitting. We are so closely associated that each knows pretty well what the other is doing, both in and out of the hospital. Fee splitting is quickly discovered and the unscrupulous doctor dealt with by the proper committee. Favoritism and special privileges must not be tolerated. They will wreck any establishment.

We have a definite time for meetings, and adhere to it strictly. It was selected to suit the convenience of our doctors. Because of this and of our carefulness not to run over our allotted time of an hour and a half, we have had almost a hundred per cent attendance at every monthly meeting. Firmly believing in the adage that "A way to a man's heart is through his stomach," we serve a delectable luncheon at each meeting.

In a Small Hospital

Uniform Accounting Is Helpful

"I NEVER was good at figures. I can work day and night with patients, but the thought of money gives me the creeps." How many small hospital superintendents have said this to themselves or to others, pointing with pride to the fact that their minds were above the sordid details of economic problems!

Yet the professional services of a hospital all rest upon an economic foundation. The serving of a meal involves the cost of food and the wages of cooks and kitchen help. The making of a bed requires the service of a nurse or an attendant. The examination of a laboratory specimen is dependent upon expensive reagents and the skill of a salaried technician. Each x-ray film or treatment increases the electricity bill for the month. A shovelful of coal in the heating plant may be the difference between safety or danger for a case of pneumonia.

Thus we may say that each errand of mercy is directly or indirectly connected with the receipt

or disbursement of cash. Conversely, each economic transaction contributes, or should contribute, to the relief of humanity. Hospital service is a group of professional procedures with an economic background. It is also a group of financial transactions with a professional objective. It is impossible to ignore either aspect of the service.

Why, then, have hospital administrators given such slight attention to the financial problems of the hospital? Why is it that a woman who will study medical case histories for hours will shrug her shoulders with disgust or impatience when the bookkeeper asks her advice or assistance concerning the same patient's financial case history?

Are You an Idealist?

I think the answer can be found in one or both of the following conditions. First, many physicians, nurses and clergymen (who comprise the group of small hospital administrators) are idealists, accustomed to dealing with charitable rather than business transactions. Their experience has been that of dispensing rather than financing charitable service. They are accustomed to rely upon rich patients or contributors to meet the costs of the important charitable services they provide. The community has perpetuated the idea of the hospital as a charitable institution, and it has only been within recent years that large numbers of the medical profession and self-supporting population have used the institution, not only as a center of public charity but as a center of professional activity.

The second disturbing factor in the situation is that financial records possess for most human beings an air of mystery and confusion. "How," says an intelligent nurse superintendent, "do you expect me, who can never reconcile my personal bank account with my check stubs, to understand or maintain the financial records of a hospital? Accounting is a mystery to me. I leave it to the initiated."

Bookkeepers and accountants have never torn away the veil of mystery, whether from cupidity or stupidity makes no difference at the present time. I contend that any intelligent administrator

TABLE I—STATEMENT OF INCOME AND EXPENSE IN A LOCAL GENERAL HOSPITAL FOR THE YEAR ENDED DECEMBER 31, 19—*

Net Income From Patients.....	\$55,700	
Operating Expenses		
Administration	\$ 6,200	
Dietary	12,600	
Housekeeping	4,200	
Laundry	3,800	
Plant Operation (Heat, Light, Power, Water)	5,500	
Maintenance and Repair.....	4,900	
Medical and Surgical Service.....	8,100	
Nursing Service	7,700	
X-Ray Service	1,500	
Other Special Services.....	1,620	
Total	56,120	
Excess of Operating Expenses Over Net Income From Patients.....	420	
Nonoperating Income		
Individual Contributions	950	
Community Chest	1,840	
Endowment Income	800	
County Government.....	1,800	
Total	5,390	
Nonoperating Expense		
Interest on Mortgage.....	3,750	1,640
Net Gain for Year.....	\$ 1,220	

*Adapted from Exhibit B, page 24 of "Hospital Accounting and Statistics," official manual of the American Hospital Association, 1935.

By C. RUFUS ROREM, Ph.D.

Associate Director for Medical Services,

Julius Rosenwald Fund, Chicago

who sets his mind to the subject can understand the financial records and reports of his hospital. Moreover, he can exercise reasonably good judgment regarding their efficiency or sufficiency, and determine whether the professional procedures are adequate in amount or quality, considering their economic basis.

Let us be specific. Hospital care costs money. What is money spent for? The expenditures for hospital operations can all be classified in one of three categories: (a) personal services of hospital employees; (b) supplies or equipment used by the hospital, such as flour, coal, soap, bed linen, stationery; ethylene, x-ray films, hypodermic needles; (c) the services of personnel or property not part of the hospital, such as law firms, insurance companies or light and power plants. Such a classification of expenditures is important as a matter of record, but does not reflect the purposes for which the expenses are incurred. It would be comparable

TABLE II—BALANCE SHEET OF A LOCAL GENERAL HOSPITAL FOR DECEMBER 31, 19—*

<i>Assets</i>	
Cash	\$ 1,000
Accounts and Notes Receivable.....	7,440
Supplies (Inventories)	2,400
Total Current Assets.....	10,840
Endowment Funds	16,000
Land	7,000
Buildings	208,000
Equipment	32,000
Total Plant Assets.....	247,000
Total	\$273,840
<i>Liabilities and Capital</i>	
Accounts and Notes Payable.....	\$ 2,800
Mortgages Payable	75,000
Total Liabilities	77,800
Working Capital	8,040
Endowment Fund Capital.....	16,000
Plant Capital	172,000
Total Capital	196,040
Total	\$273,840

*Adapted from Exhibit A, page 23, "Hospital Accounting and Statistics," official manual of the American Hospital Association, 1935.

to a medical case record in which were carefully listed the time spent by doctors and nurses and the amount of gauze or medicine consumed, but which included no record of the diagnosis or the progress of the disease.

The American Hospital Association's recent report on uniform accounting entitled "Hospital Accounting and Statistics," published May 1, 1935, recommends the grouping of operating expenses under the various functions performed in the hospital, such as administration, dietary, medical and surgical service and nursing. Under these classes are recorded the amounts expended for personal services, supplies and the miscellaneous services of outside agencies. Table I contains ten categories of operating expenses. They may be subdivided

TABLE III—COST PER PATIENT-DAY; AVERAGE FOR YEAR ENDED DECEMBER 31, 19—*

Operating Expenses	\$56,120
Patient-Days	
Adults and Children.....	13,254
Infant-Days	1,004
Total	14,258
Cost per Patient-Day (Excluding Infant-Days)	
(\$56,120 ÷ 13,254)	\$4.23
Cost per Patient-Day (Including Infant-Days)	
(\$56,120 ÷ 14,258)	\$3.93

*Adapted from Exhibit D, page 25, "Hospital Accounting and Statistics," official manual of the American Hospital Association, 1935. The calculations shown above apply to the hospital as a whole, including not only the costs of services rendered by the day, but also the various special services such as x-ray, laboratory, operating room, some of which are rendered to clinic patients or private ambulatory cases.

or combined according to the needs of the administrator. The main requirement is that all operating expenses be recorded and reported under classifications which indicate their purposes.

Let us look for a moment at the classification of hospital income—a more cheerful subject. The main sources of hospital income should be differentiated in records and reports and may be expressed as patients, volunteer contributors, governments, and invested funds. A report of hospital income should reflect the amount from each source. The administrator may wish for a further subdivision, particularly in terms of the various services rendered by the hospital, such as board and room, operating room, laboratory, but these are merely refinements of the general idea.

No hospital report is complete without a summary of assets and liabilities. An adaptation of the hospital balance sheet recommended by the committee on accounting appears as Table II.

What about cost per patient-day? Like the weather, everyone has talked about it, but no one has done much about it. The advisory committee on accounting has recommended a standard procedure for determining this item, so that hospitals

can compare their experiences with other hospitals or periods of time.

Cost per patient-day is the average cost of caring for an in-patient for one day, based upon the total costs and the total number of patient-days during a period of time. The total costs should include only "operating expenses" as defined by the American Hospital Association. The total patient-days should also be calculated according to the standard definitions. The method of determining the cost is shown in Table III.

Differences in cost per patient-day do not necessarily represent differences in business efficiency. They may indicate merely differences in quality or complexity of a hospital program, in wage levels or price levels in a community, or in percentages of occupancy during a period of time. But cost per patient-day is a convenient and useful index of hospital activity.

Finally, what should this article mean to a physician, nurse, or former clergyman administering

a small hospital? Merely this, an understanding of hospital financial transactions is fundamental to hospital administration, and is within the capacity of any intelligent administrator who will concentrate on the problem. These transactions can be expressed only in accounts and accounting reports. The recent report of the advisory committee is intended to help toward this end. The report need not necessarily be adopted or rejected in detail. Like the multiplication table, it is a subject for study rather than argument. An administrator will find much in the report which can be applied to his own institution by himself or his accountant.

A superintendent should occasionally ask his bookkeeper to explain the financial accounts. If she cannot explain them, he may rightly suspect she does not understand them. The experience will be worth while for both administrator and bookkeeper and may lead to clearer understanding of the relationship that should exist between the economic and professional aspects of hospital care.

How Lighting Affects Color in Interiors

"OUR present knowledge of colors, combinations and effects opens up vast possibilities for their use to good advantage and with consideration to daylight and artificial illumination," write Ralph Bennett and T. J. Maloney in "Paint—A Partner in Illumination" published in the April issue of the *Architectural Record*.

"Any treatment of illumination or decoration must give consideration to the emotional qualities and decorative aspects of colors as well as reflection values. This can be accomplished without serious sacrifice of any one desirable quality. Generally speaking, lower levels of illumination and colors of a more subdued, neutral or restful sort should be used in lounge rooms, lobbies, theaters and other places designed for relaxation. Brighter illumination and more stimulating colors should naturally be favored where the objective is to inspire activity or an active state of mind. This selection of suitable colors is of extreme importance.

"Inasmuch as the emotional responses usually associated with given colors may be radically altered in particular applications, consideration must be given to: (1) the color scheme or treatment; (2) the design employed, and (3) the light source.

"Black, usually classified as depressing and heavy, may assume life and snap with but slight relief from bright colors or designs that lend motion. Brilliant or subdued illumination will also alter the atmosphere considerably, irrespective of other factors.

"In specifying colors consideration must always be given to the type of artificial light to be used and to the effect of both day and artificial light on the shade of color. Certain shades of blue and green become almost indistinguishable under the tungsten illumination. Reds, oranges, yellows and browns tend to become richer. Blue becomes darker under artificial lighting, and appreciably brighter and a really pure color under daylight. Fabric colors are especially susceptible to the color values of different light sources

and may affect the entire color scheme. Colors for a room should therefore be picked with respect to day or night occupancy, or the effect of either type of light on the colors for day and night.

"If a colored surface is flooded with intense light as from spotlights or indirect luminaries, a paling or flattening effect will be produced. This condition can be avoided by directing the light against white or tinted surfaces or by diffusing the light at the source by means of opal or other types of diffusing glass.

"The use of reflectors or shades that favor a white or blue-white reflecting surface will facilitate simulating daylight quality.

"When indirect or semi-indirect illumination is to be used and the light intensity must be sufficient for good seeing conditions, white or light tints should dominate the color scheme—especially on upper walls and ceilings. Daylight received from limited window sources is also dependent upon paint surfaces of high reflection values.

"Perhaps it is because of long association with the fireplace and the warm red-yellow of candle flames that the natural yellow of tungsten lamps is so accepted and the natural yellow is often increased by the use of yellow, brown or red shades or painted reflecting areas. From the standpoint of seeing, especially for reading, or performing other close visual tasks the light resulting from lamps so treated is both harmful and fatiguing to the eyes.

"In this respect we may expect to find increased attention being paid to the quality of light from artificial sources, and reflected from paint surfaces—for paint surfaces reflect their own color predominantly. Artificial daylighting on a large scale is not entirely practical from the standpoint of initial and operating cost. The only really satisfactory daylight quality obtained by artificial methods at the present time is by using lenses over tungsten lamps which whiten the light by selective transmission."

In a Small Hospital

Nursing Is Not Simple

AS ROAD and air accidents multiply with each increase of speed or space and the small hospital automatically becomes more important to a greater number of people, a discussion of preventable deficiencies and the recognition of obvious and apparently needless handicaps to good nursing service become imperative.

The small hospital nurse seldom appears at meetings to talk over her difficulties. She stays in her hospital and meets the situations that arise with what materials she has. She has been successful, but it has been a costly success, and just how costly only she knows.

The staff duty nurses are, mostly, fresh from nursing schools and eager to work. They have returned to rural communities or small towns because nursing organizations have pointed out the future of the small hospital and the advantages of the country. Their criticism of the present day small hospital field centers around two points, both of which affect their professional happiness and their personal well-being.

The first problem is that of case load. Time and again I have been told, "We have too many patients to do our work well." "I'm not responsible for any one patient." "This staff duty is just ditch digging." As these young nurses talk, you learn that one nurse takes all the temperatures, one gives baths, another gives treatments, still another is responsible for making beds or giving medications. How lacking in satisfaction such nursing service is! At the end of a hard day a nurse should have the right to say to herself, "My patients are better today, we're winning out."

And the patient who receives such piecemeal, communistic care might also describe it as ditch digging.

A Victim of Small Town Gossip

The second thorn is recreation. Today's average young person has been taught that recreation recreates, that it is an essential part of her daily régime and essential to her well-being. Is it strange that young nurses rebel against hours of duty so long and so arduous that sleep is the only form of recreation in which they may indulge? Or that they turn longing eyes toward the cities because they know the townspeople think a nurse must

By HELEN TEAL, R.N.

Executive Secretary, Indiana State Nurses' Association

The small hospital nurse is handicapped by too many patients and too little equipment. She sleeps in a room over the ambulance entrance or within hearing of patients' bells and cries. She lacks the inspiration of staff conferences and professional meetings. If she goes horseback riding, the neighbors think she isn't busy and suggest reducing the hospital nursing staff

work so hard she can't play? The experience of one young nurse in a small town where she is much loved and respected will illustrate this point. She wanted to ride horseback. There were saddle horses available at a price she could afford, so she bought a simple riding habit and began her lessons. The town soon buzzed — "How can Miss X go horseback riding? Isn't she busy enough? Are there too many nurses at the hospital?" Discretion folded away the riding clothes. Via trolley she now goes swimming once each week in a near-by town. She has a small garden. She has made herself inconspicuous. The hospital nursing staff was not cut.

When the administrative group speaks its voices its troubles in less personal form. Condensed into three loose categories they are: (a) the community's lack of knowledge of proper hospital conduct; (b) the physical handicaps to good nursing care; (c) staff problems. Under the first of these can be grouped such statements as: "The board has no criteria to judge the value of or the need for skilled nursing care." "If the chief doctor suggests 'practical' nurses as a way to reduce overhead the board is inclined to listen to him." "The board does not understand the need for recognition of its administration by the American Hospital Associa-

tion or the American College of Surgeons." "The town encourages professional laxity in the medical staff and in the nursing staff." "People invite gossip, they magnify every statement made by the nurses, either inside or outside the hospital." "Everyone asks special favors from the nurses, giving as excuses financial contributions to the hospital."

Under physical handicaps to adequate nursing care, first honors go to lack of space for proper isolation, second, to lack of staff and equipment for proper isolation technique and third to lack of space wherein may be concealed the patient who requires so much special care that the whole house is handicapped.

When discussion swings round to staff or personnel problems, one listens with one's mind on the grading committee's report and remembers vividly the comments made by staff nurses themselves.

What Is Basic Education?

Topping the list of staff problems is "lack of basic education," reflected, so the administration group says, in the nurse's inability to parry inquiries from the patients' families and friends, to refrain from discussion of hospital incidents when visiting homes or relatives, or to provide amusement or handiwork for convalescent patients. When "lack of nursing education" is discussed one hears that nurses know only the routines of large city hospitals, that they have never learned the principles of nursing care, that they are loath to accept responsibility, are unable to work without supervision, and that they cannot manage their work well. Again one is told that it takes too much time to teach graduate nurses department routine and nursing procedures as "the local medical staff wishes them done."

As expressions such as these come reluctantly to the surface, one thinks of the disheartened young staff nurse, voicing her grievances over the same points but from an entirely different slant. One thinks again of the public health nursing services built to success from these same young nurses, "trained in the routine of large city hospitals," and one marvels at the power of staff conference methods to release creative nursing ability and to iron out administrative detail.

The last item on the trouble list of the administrative group of nurses is the twenty-four-hour service required of the nurse superintendent, the operating room supervisor, the obstetrical supervisor. Night after day and day after night they must be on duty or on call. The Fates, not the budget, govern demands on them.

If one visits these same small hospitals, one's strongest and most enduring impression is that

these nurses live too close to their jobs, both literally and figuratively, that they have no opportunity to get a perspective on their work.

Tradition apparently plays its part in the selection of living quarters for nurses. Efficiency, it seems, must be sacrificed to tradition. Behold the superintendent who, carrying the brunt of the hospital burdens of finance, nursing care and anxiety over individual patients is housed over the ambulance entrance or en route to the operating and delivery room, or, perhaps just inside the front door and the business office. Listen some day, and night, to the phone calls, the arriving and departing automobiles, families and doctors. Then marvel at the calm that withstands weeks and months and years of such nights and days, and knows no privacy.

Under the eaves on the third floor sleeps one hospital's nursing staff. An open well stairway carries every noise upward. The moans and groans of arriving patients, the sharp breathing of the postoperative patient, the querulous bells of the restless, are the night lullabies for the nurses who at 8 a.m., day in and day out, must be ready to assist the doctor in a major operation of hours' duration.

Tucked in between the nurses' bedrooms on the "east wing" is the nursery in yet another hospital. "The room was so sunny." By day the night nurses slumber amidst the calls of doctors, the inspection of relatives and the bustle of starched uniforms. By night the day nurses, with doors open to catch the coolness of the stray breeze, wake as the overhead lights switch on, the sickest baby whimpers or the feeding cases wake for nourishment.

Is such provision economical? Does it promote reasonably good care of patients? What other group of tax supported workers is asked to take such maintenance in lieu of salary? Does the school teacher expect a bed at the schoolhouse, the librarian one at the library or the town clerk one at the city hall? Is "maintenance" a community asset or a liability?

What Time Studies Show

Living literally too close to their work and in their work, small hospital nurses have little time or energy to consider their problems. Only recently have time studies been made on case loads in hospitals, a sharp contrast to the practice of that of the youngest of nursing ventures — the public health nursing service. With pleasure one reads the article in *Hospital Progress*, April, 1935, entitled "Nursing Time Requirements of a Surgical Patient." One statement therein recalled an interview with a superintendent of nurses, puzzled because a staff nurse could not give satisfactory

morning care to six mothers in private rooms in four hours! The statement referred to reads: "The nurse can take care of only four to five patients during the morning period, seven to eight patients during the evening and ten to fourteen patients during the night period. Other observers have noted that beyond a certain point of maximum efficiency, time is lost when a greater patient load is placed upon the nurse."

The time study, by taking into consideration the interruptions of physicians and friends, takes away from one's effort that breathless feeling of racing the clock. It seeks to provide the patient with quiet care. Time studies in small hospitals may reveal some surprising methods of adaptation to environment.

Broadening Professional Contacts

The next big "objective" nursing problem is the inability of nurses to attend educational and professional meetings. This difficulty is inherent in a small staff scheduled for long hours. Perhaps the nurses themselves are responsible for this fault. Certainly taxpayers have accepted as axiomatic the attendance without loss of salary of teachers at state and regional teachers' meetings and of its civil servants at political gatherings. The value of attendance at meetings is well stated in terms of turnover in the article "There Is Unity at Jeanes — Therefore Strength," in *The MODERN HOSPITAL*, January, 1935: "The conduct of a small hospital necessarily inflicts certain limitations on its employees. Department heads of Jeanes have been encouraged to broaden their professional contacts by engaging in association work. This in itself has injected new interests into the hospital life and eliminated petty misunderstanding and jealousies." Following examples on this point the author states that "In consequence it has been several years since any change has taken place in the major posts."

How many hospital administrators have used regular staff meetings as educational tools or as the means of building up esprit de corps? Next door to our association's headquarters is the branch office of a national insurance company. Here on Monday mornings all the employees — agents, officers and clerks — gather together for two hours of instruction and spirit building, their preparation for a week of bigger and better sales. Year in and year out these pep meetings are held. Why? Because that is good business. Retail stores, too, follow the same plan of staff spirit building.

In public health nursing services where this principle is applied, administrative problems are thought through together, routines analyzed and developed, techniques torn to pieces and rebuilt,

standing orders interpreted, interesting patients and situations reported until the complex mass of daily work is woven together into a web that is "our association" and "our policy."

Quite outside the control of nurses are a group of factors that should be added to the total of nursing problems. Listed for brevity they are local politics, medical staff jealousies, smoking and noise in halls and supplies ordered by the board or by trustees regardless of needs.

The practice of selecting nurses on "party lines" needs no comment here. The patient and the community bear the cost of selection by this method.

The purchase of equipment at the expense of the staff budget is a cost likewise borne by the patient. Consider this operating room with its new-fangled tools all purchased on the recommendation of a certain important man in the community. Then look into the utility room serving fifteen patients hour in and hour out. It is equipped with one small gas burner and one small electric light. Here all dressing trays are prepared in the semigloom of a room without windows, lighted by a small bulb halfway up the farthest wall. Here all hypodermics must be prepared and all sterilization by boiling must be done. All fluid drinks are heated over the small and feeble gas burner. The operating room with its choice collection lies in state upstairs used but a small portion of the time, a haughty sister to the Cinderella utility room which slows down the necessary and comforting care of patients by its unnecessary inconvenience. Go to a second hospital graced by a nursery with elaborate equipment and a small population, equipment purchased when a second night nurse "could not be afforded" for the eighteen patients sleeping in three wings and on two floors. What could the equipment have done in case of fire? It looks well to visitors, however.

The task assigned me was to set forth nursing problems in small hospitals. Their solution is left to others. I can but close as I began with commendation for the nurses who are giving satisfactory care to patients in spite of handicaps.

Preparing for Painting

Walls and ceilings which are only normally dirty do not require washing before painting, says *Buildings and Building Management*. Surfaces which are excessively dirty should be washed before painting in order to remove greasy films. It is especially important to wash surfaces in kitchens before painting because the greasy film may prevent proper drying of the paint.

Old calcimine should always be washed off thoroughly from the surfaces of walls before the application of more calcimine, paint, wall fabric or wallpaper. The same is true of water soluble types of water paints.



St. Vincent's Demonstrates Service on Hospital Day



Among the exhibits presented to the public at St. Vincent's Hospital, New York City, on National Hospital Day, were these three on child development and hospital care of the sick child, diet in health and disease, and an operating room set-up. A cross section of an autoclave is shown in the rear.



Safeguarding the Sterile Water Supply

By Major JOEL I. CONNOLLY, M.S.

Chief, Bureau of Public Health Engineering, Chicago Board of Health

RECENTLY the Chicago Board of Health served notice upon a hospital requiring changes in the plumbing connections to a newly installed water sterilizer.

Remembering our experiences with water sterilizers seven years ago, when a survey of these devices in all Chicago hospitals was made, we made a test to find out definitely what could and what could not occur. Arrangements were made with the hospital concerned to permit us to test the newly installed sterilizers. The hospital engineer observed the tests on behalf of the hospital management and two men from the board of health, of whom I was one, conducted the test.

Within thirty minutes we demonstrated conclusively that siphonage of sewage from waste pipes into the sterile water tanks may occur, even though the vacuum breakers are functioning normally. The hospital at once proceeded to correct this condition on its sterilizers and replace the faulty equipment with new apparatus.

Many hospital people are aware of the danger of polluting drinking water in the pipes by drainage from bottom connected instrument or utensil sterilizers or bedpan washers. Not so many, it appears, are familiar with the fact that when the steam condenses in a water sterilizer, the vacuum produced thereby may suck sewage up into the tank through the waste connection. Vacuum breakers are customarily provided to admit air to replace the steam as the latter condenses.

What the Test Revealed

The danger in this situation is that air cannot always be admitted through some vacuum breakers fast enough to prevent the formation of a partial vacuum as the steam condenses in the tank. It was found in our tests that because the distilled water tank and the hot sterilized water tank are connected, a vacuum is produced in both tanks at the same time. Therefore siphonage through drain pipes may occur in either tank or both.

A description of the test mentioned above may be of some value in showing how any competent investigator may check the adequacy of such equipment.

The cold sterile water tank was tested first. A compound gauge, indicating pressures both above

and below atmospheric pressure, was connected to the top of the tank below the safety valve. The drain to the sewer was disconnected and permitted to drip, with the valve slightly open, as may frequently occur. Water was admitted to the tank until it showed in the bottom of the gauge glass. The steam was turned on, until 15 pounds pressure was shown on the pressure gauge. The steam was turned off and the cooling water was turned on. This cooled the water and steam in the tank until the pressure dropped to zero and then a vacuum was produced.

Water Is Sterile or Not Sterile

As soon as the gauge registered less than atmospheric pressure, the dripping of the water from the drain ceased and air was sucked in at the point where the drain had been disconnected. A glass of water was held at the drain and water was immediately siphoned up from it into the sterile water tank through the drain. When this drain is directly connected to the sewer, there is no easy way to tell whether the valve is tightly closed or not, or whether sewage may be siphoning into the sterile water tank. The importance of preventing contamination of sterilized water and thereby avoiding postoperative infections is so great that no water sterilizer should be directly connected to any sewer or waste pipe. There can be no half-way measures. Water is sterile or not sterile. A mixture of even a little sewage with sterilized water renders it unfit for use in operating rooms.

The test was repeated with different amounts of water in the tank. With 6 inches and 12 inches of water showing in the gauge glass respectively, siphonage occurred through the drain pipe into the cold sterile water tank. When fifteen or more inches of the gauge glass were filled, the relatively small volume of steam in the top of the tank, when the steam condensed by cooling, was more readily filled by air admitted through the vacuum breaker. Therefore, a less complete vacuum was produced and the head of water above the drain pipe valve counteracted it so that siphonage did not occur under these conditions. It should not be assumed, however, that siphonage may not also occur at these levels if more rapid cooling were accom-

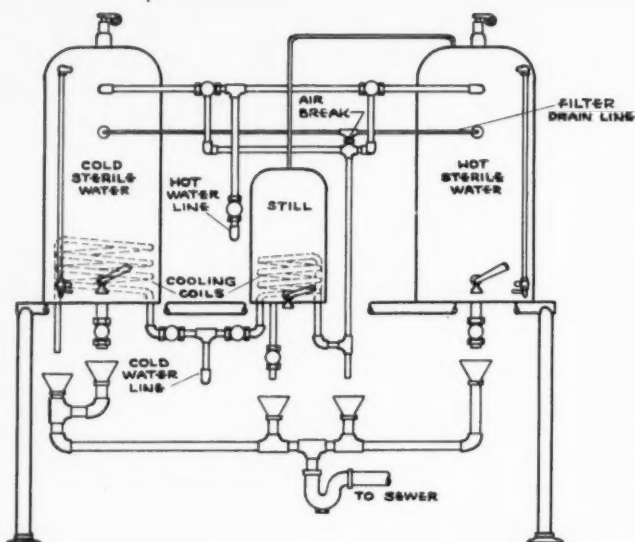


Fig. 1. Waste cannot be siphoned into sterilized water tanks, distilled water tank or drinking water system through this sterilizing apparatus, because of the complete severing of all waste pipes from tank drains and cooling coils.

plished than was done in this test. Greater volume or lower temperature of cooling water or more efficient cooling coils would do this.

Next, the hot sterilized water tank and the distilled water tank were tested together because the two tanks were connected by a pipe leading from the top of one to the top of the other. There was no valve on that pipe, so that the same vacuum is produced in both tanks at once and the vacuum breaker on the hot sterilized water tank is intended to prevent the formation of a vacuum in both tanks. Our tests showed that on this particular apparatus it does not always do so.

The gauge was moved to the top of the hot sterilized water tank, and the drain to the distilled water tank was disconnected. The valve on the distilled water tank drain was opened enough to drip. To expedite the test, only enough water was placed in the hot sterile water tank to show an inch above the bottom of the gauge glass. This was heated by steam to 15 pounds pressure, the steam was then turned off and the cooling coil in the distilled water tank was turned on.

The pressure registered by the compound gauge dropped to zero. A little later, it was decided to fill the hot sterilized water tank more completely. Immediately after the water started to enter the hot sterilized water tank, a vacuum of about four inches of mercury was shown on the gauge and the drain on the distilled water tank ceased to drip and began to suck in air. Water was rapidly siphoned into the distilled water tank from a glass held where the drain had been disconnected. Of course, at the same time siphonage from the sewer could occur through the drain of the hot sterilized water tank if its valve were leaking.

It should be pointed out that these tests showed conclusively that dangerous contamination of both sterile water supplies, hot and cold, and of the distilled water, could occur through the drain connections of the respective tanks. Also the direct connection of the cooling coil and sewer permits siphonage of sewage into the drinking water through the cooling coil, when a partial vacuum occurs in the water supply pipe.

This experience demonstrates the folly of relying upon an inadequate vacuum breaking device which cannot possibly satisfy the demand for air under every condition. True, the vacuum will eventually be broken by the admission of air or sewage, or both, but in the meantime, while the vacuum exists, gross pollution of the sterilized water or drinking water may have occurred.

Of course, master plumbers should know that cross connections of this character are dangerous and are contrary to ordinance requirements. We are informed by plumbers, however, that they are seldom, if ever, given a job of installing sterilizers, even when they have the general plumbing contract for a hospital. They have told me that they "rough in" the connections to the floor or wall, as the case may be, and that someone else later installs the sterilizing equipment and makes the connections to water pipes, sewer pipes and steam pipes, after they have left the job.

The laws of this state and city require that the water and waste connections be made by a licensed master plumber, in order to safeguard the public health, and require that the work be reported to the board of health for inspection immediately upon

SUGGESTED METHOD OF CORRECTING EXISTING STERILIZER INSTALLATIONS

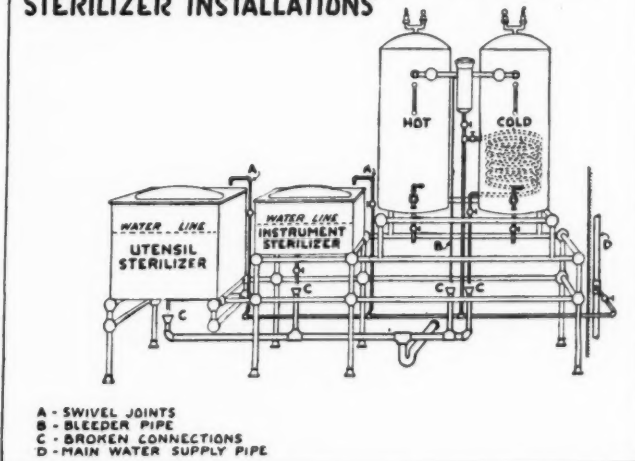


Fig. 2. When existing utensil and instrument sterilizers have direct bottom connections to water and waste pipes, the danger of contaminating with sewage may be removed by making indirect broken waste connections as shown at "C." Siphonage or draining of sterilizer contents into water supply pipes may be inexpensively accomplished by bringing the water over the top with a swivel joint, as shown at "A."

completion. No such report was made in this case, and the sterilized water was exposed to contamination for several months before we discovered the situation and sent our notice. Had it not been for the fact that Doctor Bundesen, president of the board of health of Chicago, had ordered an inspection to be made of plumbing of all hospitals in the city, our inspectors might have known nothing of this new installation for many more months or possibly years, and during all that time, the danger of contaminating both drinking water and sterilized water by sewage might and probably would have existed.

To be fair to the designer of the sterilizer, it should be pointed out that an attempt had been made to avoid the dangers of contaminating the sterilized water, though the attempt was not sufficient to remove all of them. Sewage inherently dangerous to health could enter the sterilized water through leaky valves on the drain lines. Our test demonstrated in convincing fashion that in this case the pipe connections were not so made as fully to protect the sterilizers against pollution from the waste or drain system.

Every Hospital Should Be on Guard

There is no desire to undermine the peace of mind of hospital executives, but on the other hand, there is no sense in closing our eyes to the fact that such dangers may exist in almost any hospital. Our observations indicate that few supposedly sterile water supplies in hospitals were actually sterile before we made our 1928 investigations which led to widespread changes in the connections to sterilizers in this city. Other investigators elsewhere have had similar experiences since then.

Another item of design merits some attention. The drain pipe which is connected both to the blow-off valve in the distilled water tank and the cooling coil in that tank, is supposed to be protected from sewage contamination by an open connection with the waste pipe. The vertical distance between the top of the funnel of the waste pipe, (to which level sewage may rise if the capacity of the waste pipe should be overtaxed or a stoppage should occur) and the bottom of the drain pipe above, was not much more than one-eighth of an inch. The person who installed the sterilizer and connected the pipes had made the upper drain pipe longer than necessary, so that it extended down into the air gap, where it could readily be seen.

All those who are familiar with hydraulics recognize that a swift rush of air into a pipe may carry water up into the pipe in the form of a miniature waterspout, the distance it will raise the water depending upon the velocity of air motion, size of pipe and other factors. Our experience indicates

that a high vacuum may lift water in this manner across an air gap of considerable width, under favorable conditions, and also it is well known that a nearly perfect vacuum may occur in water pipes in buildings. It is our belief that the air gap between water and waste pipes should be great enough to give complete protection against sucking sewage back into the water pipe (possibly 1½ inches), or that efficient and reliable means should be used to prevent the formation of a vacuum in the water pipe. Some of these means will be discussed in a forthcoming article of this series.

To illustrate the powerful effect of a vacuum, let me cite an example that I noticed in another hospital. The engineer found one day that the cooling coil in his cold sterilized water tank had collapsed because of the vacuum which occurred in the water

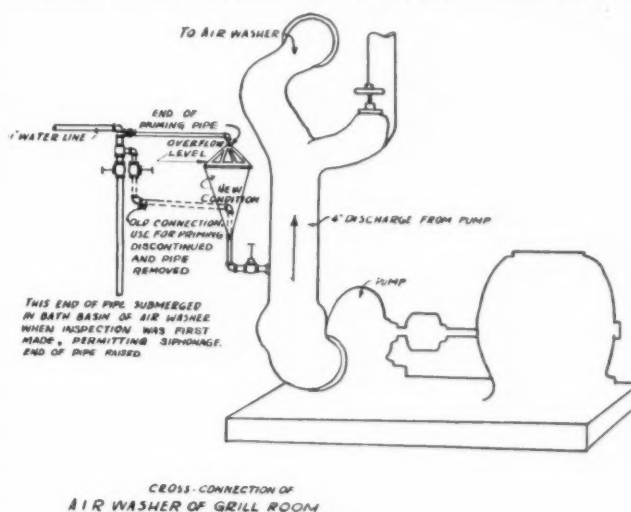


Fig. 3. Cross connection for priming a pump. Dotted line shows direct cross connection which permitted dirty water from air washer to be pumped into drinking water system. This connection was removed and funnel arrangement substituted. Dirty water will overflow on floor through triangular openings at top of funnel and not reach the filling pipe above. Also end of pipe submerged in basin permitted siphonage of dirty water into drinking water pipes until end was raised above overflow level.

pipe. This coil was directly connected with the waste pipe. Consequently, he installed a new cooling coil and put a little swing check valve on the waste pipe at the outlet side of the coil, so that it would open to admit air to prevent the recurrence of any vacuum and collapse of the coil.

He was doing what he could to save himself the work, expense and annoyance of putting new cooling coils in the sterilizer, but at the same time, without consciously attempting to do so, he was giving a certain measure of protection to the patients of that institution against postoperative infections and to all persons, staff and patients alike, against pollution of their drinking water by sewage sucked back through the cooling coil into the general water supply. We advised a complete



Fig. 4. An innocent appearing device, dangerous because in use it may permit sewage contamination of drinking water. Water pressure is used to force obstructions from waste pipes, by connecting hose to faucet as shown here.

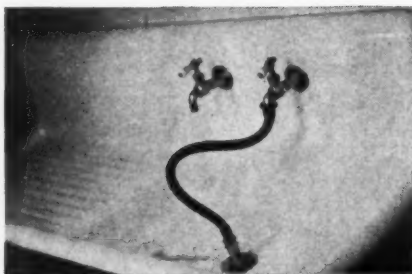


Fig. 5. Drain cleaner shown in Fig. 4 connected for use in removing stoppage in a sink drain pipe, forming a direct cross connection.

severance of water and waste pipes, because of the well recognized unreliability of check valves for protecting against contamination,¹ thus adequately protecting drinking, sterilized and distilled water supplies against dangerous pollution, and also giving the engineer assurance that no more cooling coils in the sterilized water tank would collapse.

Several cases are known where sterilized water reservoirs have completely collapsed, due to failure of vacuum breakers to function.

Where a device is employed to prevent the creation of a vacuum, great discrimination must be shown in selecting it, to assure that it will do the work expected of it, but that is not all. It must be frequently inspected to be sure that it is in working condition, unless its construction is such that it cannot fail. Even so, the most foolproof protection yet devised, a complete disconnection of pipes, has been rendered inoperative because of the personal element.

In a hotel we had ordered that a priming connection from a water pipe to the circulating pump of an air washer be broken, to prevent pumping dirty water from the air washer pan back into the drinking water supply. This order was duly carried out by the hotel, as shown by subsequent inspections.

An Embarrassing Moment

One day I was showing an engineer certain things in this hotel and, coming to the room where this priming connection had been broken, I said, "Here is the place where there used to be a cross connection," and I opened the door. We went in and to my embarrassment, we found that it had been reconnected, just as it had been before we

ordered it changed. Then we required the substitution of a funnel arrangement shown in Fig. 3, to avoid the temptation to reconnect the forbidden pipe.

Just as prohibition did not exist under the Volstead Act where public opinion was opposed to it, so safety against dangerous plumbing installations will be a chimera in any building where the persons in responsible charge do not want safe plumbing enough to be vigilant and watchful.

Interest in plumbing in buildings from the public health standpoint has had two stimuli originating in Chicago. In May, 1928, our previous work on hospital sterilizers was reported to the Illinois State Medical Society, at its annual meeting. An exhibit of sterilizers in working condition was shown, illustrating contamination of drinking water by drainage from bottom-supplied instrument sterilizers, and the subsequent leakage of this polluted water through defective or incompletely closed valves into the sterilized water tanks.

During the following few years, papers or exhibits, or both, dealing with this subject were presented by representatives of the Chicago Board of Health to many national, state and local organizations. Papers given at these meetings were published in various journals, some of which are mentioned in a list of references on page 136 of the American Public Health Association Yearbook, 1930-31.

Survey Made in Kansas

In some localities and even throughout areas of considerable extent, sufficient interest was aroused to lead to the making of surveys of hospital sterilizers. In most cities, however, relatively little has yet been done to correct old installations. The state board of health of Kansas made a survey and the results, reported by R. E. Lawrence to the Kansas State Medical Society,¹ indicate that the situation throughout the state was similar to ours in Chicago before our studies of 1928 and subsequent changes in equipment. Mr. Lawrence says, in part, "A total of 44 samples were collected from water sterilizers and analyzed in the water laboratory. In no instance was a sample of water found to be absolutely sterile. All samples were free from organisms of the Coli-aerogenes group. However, total counts ranged from one to ten thousand per cubic centimeter, with a good percentage showing a total count over one hundred bacteria per cubic centimeter." This work developed a keen interest among the master plumbers of the state.

Information reaching us from plumbing inspectors and health authorities, as well as a limited

¹Bundesen, Herman N., Health Hazards in Plumbing, The MODERN HOSPITAL, April, 1935.

¹Lawrence, R. E., Study of Defects in Hospital Sterilization Practice, J. Kansas M. Soc., June, 1932.

number of observations by members of our staff, indicate that hospital water sterilizers in far too many cities are still subject to the same sort of objections as they were seven years ago, when these hazards were first brought to the attention of the public.

In recent years a number of city and state health departments have become more active in this matter, especially those with well developed sanitary engineering divisions. The Mayo Clinic, Rochester, Minn., has had an earnest advocate of safer plumbing for a long period in the person of Dr. Thomas B. Magath. The New York State Department of Health has given wide publicity to dangerous sterilizer connections in the columns of its *Health News*, and has made a special study of such apparatus in state institutions. At the request of the Chicago Hospital Association, the University of Wisconsin started investigations of certain types of fixtures in 1930, and these have led in turn to other studies which have been continued up to the present time.

After the force of the 1928 stimulus to safer hospital plumbing had spent itself somewhat, something happened to revive the flagging interest in public health and plumbing. Curiously enough this second impetus also originated in Chicago. It was the discovery that the great outbreak of

amebic dysentery among guests of two hotels here during the 1933 World's Fair probably was caused by contamination of drinking water because of defective plumbing. Details of this outbreak will be given, in brief, in an article soon to appear in *The Modern Hospital*.

Doctor Bundesen has received literally hundreds of invitations to tell of these discoveries to groups in all parts of the civilized world. Most of such requests have had to be declined, because of distance and lack of time. However, others have not been backward about giving their opinions. Among papers and exhibits featuring our discoveries made in our study of this outbreak, physicians, engineers, architects, plumbers, building owners and the public have found things to intrigue their interest. Moving pictures of amebae, photographs of dangerous plumbing defects, and even a glass working model of a hotel plumbing system have been used.

Radio broadcasts in nontechnical language on this subject have also been given upon special request over a considerable number of stations. This widespread desire to learn all about the causes of the epidemic and how to overcome them indicates the increase in intelligent understanding of the problems of plumbing that face hospitals and hotels alike, and a willingness to overcome them.

Tips to Executives on Saving Power Dollars

A group of articles designed to broaden the executive conception of the power job and thereby ensure the engineer fuller cooperation in the big task ahead—saving American industry the hundreds of millions of dollars now lost annually in preventable power waste—appeared in a recent issue of *Power*. The startling accusation is made that "fifty cents of every power service dollar is wasted."

Hospitals probably are just as guilty as industrial plants when it comes to wasting power, and hospital executives, like industrial executives, need to cooperate more closely with their power engineers. Following is a summary of the suggestions made in *Power* that have particular significance to hospitals:

"1. In buying power be sure that you operate under the best available rate schedule. See that plant personnel and the mechanical and electrical equipment are set to avoid the dollar penalties which schedules impose upon low power factor and demand peaks.

"2. What is your boiler room overall efficiency in per cent? Eighty per cent is good, 70 is fair, 60 is bad and 50 something to blush about.

"3. Be sure you have made the best choice among coal, oil and gas fuel. When installing new fuel burning equipment, select equipment that will allow the maximum freedom of fuel choice. Thus you can snap up future fuel bargains when they appear. It sometimes pays to burn 'poor coal' if you have the knowledge that will enable you to

select it and have the right kind of equipment to handle it.

"4. Earmarks of an efficient boiler room are: Plenty of light and air, intelligent operators, mechanical coal and ash handling, mechanical firing, mechanical draft, high-set boilers and not too many, an adequate installation of meters and instruments and automatic control, hot and scale free feed water.

"5. Overheating is the direct cause of large waste of heating steam. Thermostat control, orifice control, vacuum operation, all help to reduce this loss. Consider unit heaters for large open spaces.

"6. Ventilating and air conditioning are specialties. Consult specialists for the best service at lowest cost."

Salesmen Merit a Courteous Hearing

Proverbially, salesmen are a tribulation; actually, says W. Mezger, superintendent, Knickerbocker Hospital, New York City, they can render the busy hospital executive a valuable service. They should receive an audience and the superintendent or his assistant should contact as many as possible personally. They keep the superintendent in touch with new developments and practices in other hospitals, with competitive prices, and with general information in hospital and allied fields. Advertising literature that comes to his desk through the mail should receive his attention to the extent of being destroyed as useless, filed for future reference, delegated to a department head for further investigation or answered by himself.

A Children's Clinic That Has

THE out-patient dispensary of the Children's Hospital, Cincinnati, which functions as an appointment clinic, has on its active roll at present 2,873 children. A total of 20,306 visits were made during 1934. A material increase in the demand for this type of service is shown by the fact that the clinic visits over the first nine months equaled those of the entire year of 1933. Children up to the age of fifteen years are eligible to attend the clinic, regardless of their color, creed or place of residence, if they cannot afford to pay a private physician.

The medical organization of the out-patient dispensary is identical with that of the hospital, and is affiliated with the college of medicine of the University of Cincinnati. The organization of the out-patient dispensary is designed to fulfill four functions fundamental in any institution: to give the best possible medical care to patients; to help carry out the teaching program of the medical college for undergraduate and graduate students; to carry on clinical investigation and to further the practice of preventive medicine.

Every child enrolled must first visit the pediatric

By FRANCIS R. VAN BUREN

Superintendent, Children's Hospital, Cincinnati

clinic where a complete history is taken and a physical examination made by the resident staff of the hospital, under the supervision of some member of the faculty of the department of pediatrics of the college of medicine. The resident staff of the hospital consists of men who have already served a rotating internship and are planning definitely to enter the specialty of pediatrics. Physical examinations and histories are written on definite forms which do not rely upon the memory of the individual physician, but make definite suggestions both for positive and negative findings.

Any patient requiring special service can be referred to one or more of thirteen consultation clinics. These include surgical, fracture, ear, nose and throat, ophthalmology, orthopedic, dermatology, anti-luetic, psychiatric, nutrition, diabetic, allergy, cardiac and dental clinics. All of these are staffed



The record room showing doors of dumb-waiter connecting direct with the admission desk of the clinic to which patients' charts can be speedily dispatched when called for.

s Vindicated an Experimental Idea



by members of the faculty of the college of medicine specializing in each particular line. The pediatric clinic is held four afternoons a week from one to five o'clock, with four resident physicians and two attending physicians present. Consultation clinics are held at various regular intervals depending upon the demand for their services.

The duties of the administrative office include the original enrollment of patients, the supervision and administration of the appointment system and the investigation of broken appointments. This work is carried out by a registrar, two paid assistants and two volunteer workers under the supervision of the executive director of the clinic, who happens, incidentally, to be director of the social service department. The volunteers meet the patients as they come in, conduct them back to the examining rooms and act as dispensers of prescriptions and medicines and as cashiers.

Some patients come to the clinic of their own accord; some are referred by various social agencies about the city; a large number are referred by private physicians, and some are those, who, discharged by the hospital, have been asked to return for further treatment or for check-up on the progress of their recovery. A large majority of appointments are made over the telephone. If the patient is new to the clinic, enough questions are asked to determine whether or not the particular child is

acutely ill or suffering from a contagious disease, in which case he is referred to the city district physician. An effort is also made to determine as nearly as possible whether or not the members of the patient's family are financially able to pay a private physician. If a patient has been under the care of a private physician he is asked to bring a note from his doctor requesting that he be enrolled in the clinic.

Each patient is scheduled for a definite day and a definite time, and insofar as possible he returns to the same physician in the pediatric clinic on subsequent visits. This allows the physician to follow the condition of each child over a period of time. In making appointments, thirty minutes are allowed for patients new to the clinic in order that the physician may have ample time to make a complete examination. Return visits are scheduled for fifteen minutes each.

On the arrival of a new patient, the parents are taken to a small room just off the main waiting room and interviewed by the registrar who takes a detailed financial history. This includes the income of the family, its source, the number of dependents, and expenses, including rent, outstanding debts and insurance. Patients remaining in the clinic

The pharmacy serves both the out-patient dispensary and the hospital proper. A dumb-waiter connects it with the cashier's office which is on the floor above.



One of the five examining rooms. Opening off of it is a small dressing room from which there is a door into the hallway.

are re-interviewed and a new financial history taken approximately every six months in order to determine whether or not their financial situation has changed sufficiently to exclude them from the clinic.

No case is admitted if the income of the family is sufficient to enable them to pay a private physician. This is determined by means of an arbitrary family budget classification based on the number of the members of the family and the income and obligations of the family. We are at present in the process of recalculating the budget because of the change in prices which has taken place since the last budget was determined.

The clinic fee is fifty cents for the first examination, and twenty-five cents for all later examinations, if the family can afford to pay this. Over 50 per cent of the children brought to the clinic, however, can afford to pay nothing.

Since patients are seen only by appointment, these appointments are scheduled in the appointment book so that it is possible to know not only how many but which particular patients will be coming to the clinic on any one day. At night, the medical charts for the next day are requisitioned from the central record room and are on hand at the admitting desk when the patients arrive. These charts are filed under the unit history system and include a complete record of each child for all admissions both to the in-patient and out-patient departments.

Volunteer Worker Greets the Patient

The volunteer worker who meets a patient on his arrival stamps the chart with the name of the particular clinic which he is to attend and escorts him to the temperature and weighing room. Here the nurse in charge or the child's mother, undresses him in a curtained cubicle after which he is wrapped in a blanket, weighed and his temperature taken. He is then sent back to the examining room. It is at this point, as well as in the main waiting

room, that any symptom of contagious disease is discovered. If there is the slightest doubt, the patient is immediately taken to one of the four isolation rooms described in a previous article.

After the physician has completed his examination and made his notes on the progress sheet, he makes a further notation as to the day on which the child should return to the clinic. After the patient is dressed he passes the cashier's desk where he receives any medication ordered and at the same time pays his clinic fee and the cost of the medicine, if possible. From the cashier's desk he goes to the registrar who gives him his next appointment written on a white card which he brings with him on his next visit. The appointment is recorded at the same time in the appointment book and a notation of the time of the next visit made on a special sheet of the chart reserved for this purpose. This sheet shows every appointment which has been given him and whether or not they have been kept, broken or canceled. It is thus possible to have an appointment record on every patient's chart making it impossible to lose track of any case from the time the patient is enrolled in the clinic until the patient is discharged and the case is definitely closed.

Not Discharged When Recovered

One of the unique features of the Children's Hospital out-patient department is that a patient is not discharged when he has recovered from any given illness, but continues to come to the clinic for general periodic health check-up and advice until he reaches the age of fifteen years. This, in addition to routine immunizations and vaccinations is part of the emphasis on preventive medicine characteristic of the best modern pediatric practice. It also enables the same physician who has seen the child when he was ill to see him after he has recovered.

One of the greatest difficulties in running an appointment clinic successfully is the matter of broken appointments. Should there be many of these, the physician's schedule cannot run smoothly and there will be unnecessary delays between appointments. In order to reduce broken appointments to a minimum, the registrar and her assistants make every effort to impress upon the patient's family the necessity for keeping appointments or for notifying the office in advance should they be unable to do so. No reliance is placed on the patient's remembering the date of an appointment more than six weeks ahead. A reminder card is mailed one week before the day of appointment. This reminder is a stamped double postal card requesting that the patient return one-half of the card stating whether he will or will not be

able to keep his appointment. At the present time the percentage of kept appointments is averaging over 85 per cent, and this we believe is almost as high as can be expected. In order to offset the number of appointments broken without notice or canceled at the last minute, two or three extra appointments are placed on each physician's schedule. Each physician assigned to the clinic sees three new and ten old patients, or, when there are not sufficient new patients, sixteen old patients every clinic day.

Every effort is made to continue a child in the clinic who needs medical care. If an appointment is broken, an attempt is made to reach the family by telephone. Most patients do not have telephones, but they usually have a neighbor who has one, and an attempt is always made to get a near-by telephone number at the first interview. If the telephone call fails to bring results it is followed by a series of two broken appointment notices asking the patient to get in touch with the clinic for a new appointment. If no reply is re-

ceived to these cards, the case is definitely closed unless the diagnosis is a serious one, in which case the matter is referred to the social service department for a home visit in an attempt to enlist the cooperation of the parents. We feel that this careful follow-up system is particularly justified because we are dealing with children who are in no way responsible for the lack of cooperation shown by their parents and they should not be allowed to suffer for what is, after all, not their fault.

After three years of trial we feel that with little extra administrative cost a service has been built up in which each child gets the same individualized attention and interest in the development of his health, growth and personality that he would get were he going to his own private physician. In addition, the patient has the advantage of such modern technical hospital facilities as x-ray, laboratory procedures and consultation service, which help the clinic physician to understand better both the patient's mental and physical problems.

July Fourth—at the Hospital

FOURTH of July at Newton Memorial Hospital, Newton, N. J., started out much the same as any other day, according to Charlotte Janes Garrison, superintendent.* The kitchen was busy from six o'clock on, preparing breakfasts for the twenty patients, and for those who care for them. At seven the laundry started with extra work caused by the full Monday morning of surgical operations. At eight the laboratory and x-ray rooms began to function. Breakfasts had been served, and the nurses had started out to make a comfortable holiday for their charges.

"It's so quiet up here," remarked an early visitor. "You would never know that it was Independence Day!"

At 9:30, at Swartswood, a Brooklyn cherry picker fell from a tree, with severe injuries, landing him in the accident room at 10. Then x-ray, laboratory and a comfortable bed and close attention from attending and resident physicians helped him through the day. (The day previous a thirteen-year-old lad fell from another cherry tree, also in Swartswood, fracturing both arms, requiring x-rays and splints; a fifty-six-year-old woman, who had climbed a tree for cherries for a pie, fell, with resulting injuries that were cared for in the hospital accident room.) At 12:30 noon, the littlest patient underwent a minor operation which was interrupted by the frantic pain of two badly burned women who were rushed into the accident room. Later they were admitted as patients.

"Still," thought the folks on duty, "it might be any day, except when cherries are not in season!"

At dinner time, the dietitian sprang her little surprises for the stay-at-homes. Each tray had a bouquet of red, white and blue flowers from the garden of Elizabeth Case, secretary of the Garden Club. Then there was Mrs. Howell's

best fricasséed chicken, and Lynn's homemade ice cream, and Miss Sanford's pink lemonade for everyone. A white-faced marshmallow man, in red, white and blue uniform, reminded folks of the Spirit of 'Seventy-Six. And Mina who has seen 402 hospital days come and go, with their 1,206 trays, found herself attending a basket picnic under the shade of the one tree on the lawn. In her wheel chair, she enjoyed her outdoor party with a younger sister.

At two o'clock Baby Joseph astonished everyone by trying to whistle. Formerly his chief accomplishment was the constant wailing of an eleven-months-old infant for his mother. Joseph is one of three children operated on on Monday for a crippled condition and is doing nicely. One hour later occurred the long expected accident—a fire-cracker burn. A thirty-five-year-old gentleman of Newark sought relief in the accident room where he was treated with tetanus antitoxin, lest the dreaded lockjaw result. The state police sent another patient for this same preventive treatment.

Upstairs, thirteen-year-old George lamented his absence from the firing line—the first time in ten years, he added regretfully, that he hadn't fired crackers. A former busy carpenter, confined for weeks in one uncomfortable position, from a spinal operation, was allowed to move on his side as desired. A woman patient was allowed to sit up in a chair, for the first time in weeks. A call came for oxygen for a critically sick patient—

Down in the town the sharp spit of crackers and cannon floated up to the hill. As the light disappeared the fireworks of Lake Mohawk were visible to those lying near the south windows.

"It's been so quiet up here," the last town visitor said. "You would never know that there had been a Fourth of July."

*Adapted from publicity describing the observance of July 4, 1934, at Newton Memorial Hospital, Newton, N. J.

The Plight of the Chronic Patient

By MARY C. JARRETT

Welfare Council of New York City

MEDICAL progress in the last half century has put the whole subject of chronic illness in a new light. The word "chronic" is a somewhat unprecise term, but it is useful to distinguish broadly between the acute type of disease that comes quickly and in a fairly short time results either in death or complete recovery, and the prolonged disease process that usually has a gradual beginning and either leaves some trace of bodily injury even after practical recovery or inevitably progresses.

Frequently, however, it is not the chronic disease that is the final cause of death, and there is some truth in the saying that a chronic disease is the best health protection, provided that competent medical care is available. The old caption "chronic and incurable" is passing away, as chronic diseases are being brought under control and the medical profession is turning more and more to the study of these problems, which many years ago Dr. Alfred E. Cohn pointed out are "admittedly the most difficult which have been attempted in the realm of medical biology. Their understanding involves a knowledge of many collateral sciences; of physics and chemistry; of mechanics; of the applied techniques which are the hand-maidens of these disciplines. Difficult as the problems are, they must nevertheless be met if society wishes seriously to alleviate its own suffering."¹

Another traditional misconception that must be laid aside before this problem can be faced squarely is that chronic illness is a matter of age or of premature old age. Many years ago the Massachusetts Department of Public Health recognized the significance of chronic disease in middle life by establishing a special division of adult hygiene. The survey of chronic diseases conducted by it, from 1929 to 1931, showed that the period of youth is also decidedly involved, for in the population under the age of twenty, the rate for persons sick with chronic disease was 18.5 per 1,000 persons.

In the Welfare Council's study of chronic illness in New York City,² a third of the incapacitated and dependent chronically ill persons cared for by

medical and social agencies were under sixteen years of age. The rate of disabling illness among the urban relief population, in May, 1934, just published by the Federal Emergency Relief Administration, in a preliminary report from its survey of occupational characteristics, reveals a staggering burden of chronic illness among those who are now dependent upon public support. More than half of those over fifty-five years of age suffer from chronic disabilities, and nearly a fourth of those between thirty-five and fifty-five years of age. The rates of the younger age groups are far from negligible — 74.8 per 1,000 of those between sixteen and twenty-five years of age and 128.9 per 1,000 of those between twenty-five and thirty-five years of age, and even in these age periods the degenerative types of disease are among the leading causes of disability.

Vital Importance of Medical Care

Of all the persons with chronic disabilities in this survey, nearly two-thirds were either employed or seeking work. This fact points to another misconception that must give way, for the "chronic sick" are not all incapacitated for active and useful lives or permanently incapacitated, even though they may be so temporarily and may never be able to follow their customary régimes. An individual may live comfortably and productively under circumstances suited to his particular chronic disability, but he will become a confirmed invalid under adverse circumstances. Many persons who are never thought of as being ill have chronic disease conditions to which they have learned to adapt themselves satisfactorily. Another person with a similar disease becomes an invalid because he is less fortunate in securing the services of a medical attendant.

Chronic illness not only is an economic problem of the first magnitude in itself but it also creates many serious economic burdens that the community must eventually bear. There are comparatively few families even among those of the comfortable middle income group who can bear the expense of a protracted serious chronic illness without going in debt or making unjust inroads upon the vitality of other members of the family. For a family of small means, the cost of caring for

¹Cohn, Alfred E., *The Significance of Chronic Disease From the Point of View of Mortality Statistics*, an address delivered at the thirty-seventh annual meeting of the Montefiore Hospital, New York, 1922.

²Jarrett, Mary C., *Chronic Illness in New York City*, published for the Welfare Council of New York City by Columbia University Press, 1933; 2 volumes.

1. *What chronic illness means to the community*
2. *What is not being done for the chronically ill*
3. *The first essentials of a community program*

a chronic invalid is apt to be an impossible burden. This situation is generally recognized in regard to illness due to tuberculosis or mental disease but comparatively little attention has been given to the economic problems of chronic sickness of other types. Besides the tremendous burden of expense for the care and maintenance of the sick that chronic illness imposes upon the community, it is the chief source of an enormous waste of money for patent medicines and services of the various "healing cults."

There is little homogeneity among the chronically ill in respect to age, degree of incapacity, character and duration of disease or type of care required. One thing they have in common is their need for individual study and painstaking and prolonged treatment; and this, as a rule, they do not receive. Tuberculosis and mental diseases, and to some extent cancer, are exceptions. There are also a few institutions for other chronic diseases that are exceptional, notably Montefiore Hospital in New York and the Robert Brigham Hospital in Boston.

In general, chronic patients when not exhibiting acute symptoms receive but casual attention. There are many reasons why this has been so — insufficient medical knowledge, complexity of the factors in treatment, lack of necessary social services, scarcity of information about the subject as a community problem, and general public ignorance of the nature of chronic diseases — but these aids to inertia are gradually being removed. There is no doubt that well organized application of what is now known about the prevention and care of chronic illness would bring untold benefits to patients and to the community.

What Is Not Done for the Chronic Sick

The conditions found in New York City by the survey made recently by the Welfare Council are probably similar to those in other communities throughout the country. The report presents a scene of great disorder and haphazard efforts to care for chronic patients — general hospitals overloaded with long-time chronic cases; patients in homes for the aged not equipped for their care; in convalescent homes intended for other purposes; in hospitals when they would have been better off

in less complex and more homelike institutions; at home when they should have been in hospitals; in hospitals when they should have been at home; in the care of family service agencies with no medical attention; cared for by public health nurses when a visiting worker would have met their needs.

Three-fourths of the patients were cared for by private agencies and one-fourth by public agencies, although this is essentially a burden to be carried at public expense rather than by private philanthropy. The city has been without policy or plan for caring for the chronically ill, other than the tuberculous and the mentally ill, and its institutions for this class of patient are antiquated and distressingly inadequate. The present commissioner of hospitals, Dr. S. S. Goldwater, is making a vigorous attack upon this situation and it is believed that before the term of the present administration ends, steps will have been taken to ensure the development of a modern medical center for chronic diseases in a central location and that policies regarding care of chronics will have been established.

Why Doctors Seem Helpless

In a recent address, Doctor Goldwater drew a vivid picture of the unhappy situation that confronts the physician in the treatment of chronic patients who require long hospitalization: "Clinically speaking the familiar type of chronic hospital presents a miscellany of chronic cases superficially observed and relatively neglected. The conditions in these hospitals are certainly not such as to elicit the best efforts of the medical staff. Picture the mental reaction of a physician who is confronted with a score of puzzling problems at one time, and who has no means at his disposal for the serious consideration or concentrated study of any one of these problems. He is so overcome by a sense of his helplessness, that he is more than likely to shrug his shoulders and to content himself with prescribing placebos. . . . Now, I am absolutely sure that the defeatist attitude of most physicians toward chronic disease hospitals would change completely if the cases could be sorted out and classified so as to facilitate close observation and study. If anywhere in the United States there is a community that is handling this problem satisfactorily I should like to know of it."¹

In facing the problem of chronic illness as a matter of concern to the whole community, it is obvious that the efforts of both public and private agencies must be combined. It is also fairly obvious that an orderly approach to the problem must

¹Goldwater, S. S., *The Hospitalization of the Chronically Ill*, a radio broadcast by the National Broadcasting Company, April 18, 1935. Printed and distributed by the committee on chronic illness of the Welfare Council of New York City.

recognize a great variety of complex special problems growing out of chronic illness and requiring many different special services, which will vary according to local conditions. There are, however, some fundamental features of a plan for the reduction of chronic illness and the care of the chronic sick that seem to be applicable to any community.

Some essentials of a community program are:

1. Recognition that society has the same responsibility for the chronically ill as for the acutely ill.

2. Recognition that chronic diseases constitute a great field of public health work in which only a beginning has been made. During the present economic depression, when the expense and strain caused by illness is an added factor in undermining the stability of families and exhausting their resources, it is more than ever important to create public consciousness of the chronic diseases as a great congeries of health problems to be undertaken with the same outlay of energy and expenditure that has brought acute diseases under control to such an astonishing degree.

3. Recognition of public responsibility for the care of the chronic sick through tax supported services. This principle now fully accepted in regard to tuberculosis and mental diseases is no less applicable to these other forms of chronic disease, which do not endanger the safety of the public through contagion or violence but do seriously affect the health and welfare of the community in less obvious ways.

How the Hospital Could Serve

4. The establishment of a modern hospital for chronic diseases. Such a hospital would be a center for medical education and research and for progress in the various branches of chronic medicine. It would be provided with all the special services required in the treatment of chronic diseases, such as social service, public health nursing, occupational, recreational and physical therapy. It should have an out-patient department for the after care of patients able to leave the hospital. It should also have a custodial department, under medical and nursing direction and closely coordinated with the hospital, for the permanently disabled whom hospital care can no longer benefit and who cannot be cared for at home.

5. The adoption of a policy in regard to home care for the chronically ill. Even when all necessary medical, nursing and social services are provided and financial assistance is given as required, home care is much more economical than institutional care, which calls for large capital investments. For many chronic invalids, care at home or in a foster home is a much happier solution.

6. Study of the extent to which social and eco-

nomic factors contribute to chronic illness caused by different forms of disease and the possibilities of preventing disability through social services. Little is yet definitely known about the effect of social factors in the causation of chronic disease or the results to public health of adequate social service. It is known that sickness is more frequent among the lower income groups, and that illness and dependency are mutually related as cause and effect.

7. Provision for the integration of mental health services with medical services in the study and treatment of chronic diseases. That psychic factors play a large and important rôle in the causation and continuance of chronic illness is vaguely recognized, but provision for employing the measures known to psychiatry in dealing with these factors is still rare.

8. Differentiation of the particular physical, mental and social problems of childhood and youth, middle age and old age, peculiar to different forms of chronic disease and requiring special measures for their prevention and treatment.

9. Definition of the policies of the different types of private agencies that assume responsibility for the care of the chronically ill and formulation of standards for the discharge of this responsibility. The types of chronic illness that will be benefited by a period in a convalescent home should be defined. The policies of public health nursing organizations, medical social service departments, sheltered work agencies, and family service agencies in regard to their responsibility in the care of different types of chronic patients are in need of formulation. The function of the so-called "homes for incurables" should be restricted to nursing and attendant care with adequate diagnosis before admission and medical supervision ensured through affiliation with a chronic hospital. The policy of private homes for the aged should be revised to permit admission of the chronically ill aged in need of attendant care and of some who are prematurely aged through chronic illness. They also should be affiliated with a chronic hospital.

A Field for Research

10. Carefully planned research in chronic diseases. For the understanding of the complicated and obscure bodily processes that cause chronic illness and disability, enormous sums must be spent for research and clinical investigation. Cancer is an example of a field in which large expenditures for research have brought increasing benefit to mankind. The private philanthropic foundations are now showing a tendency to support research in other chronic diseases.

Distinguished Service— Through Public Education

LITERALLY hundreds of suggestions for the improvement of hospital service have been made by executives in this canvass of ideas. Behind these suggestions offered in solution of the problems that exist in the hospital today, there is, undoubtedly, a fairly well rounded view of the whole field.

The services and material facilities of hospitals are not being used as extensively as they could and should be, and philanthropic support of hospital service has fallen off. The public need of hospital services is probably greater than it ever has been, yet that need is only partially met because certain large areas needing hospital facilities do not have them; the cost of service seems beyond the reach of persons with moderate and low incomes; there is a lack of organization and operation that will provide care for the kinds of sickness many persons have;^{1, 2} the public has not been educated to a knowledge of how important hospital service is and how much service the hospital can provide.

The preponderant suggestion is that of increasing the out-patient and ambulatory services of the hospital.^{1, 2, 3, 4, 5, 6, 7, 8} The explicit suggestions are numerous. One group which has had a great deal of experience advises that ambulatory service at the hospital be organized and promoted for the use of private physicians so that all diagnostic and treatment facilities of the hospital may have a larger use under the direction of private physicians.³ The same group especially urges the immediate extension of hospital laboratory facilities to private physicians for the care and treatment of indigent ambulatory cases.

Others give a slightly different turn to their suggestions. They say in effect that present economic conditions produce an unusual situation; occupancies are at a low point. Thousands need the ambulatory services which a hospital can give, for the facilities are available and are not used to anything like capacity. Ambulatory service (and even in-patient service) could be extended at little additional expense to the hospital. It is also pointed out that this extension of service would stimulate and encourage those young men who have entered the practice of medicine during the

Publicity, good publicity is an open sesame to distinguished hospital service. If your community needs to be educated, proper publicity will solve your problems. In this fourth and concluding article on distinguished service innumerable suggestions are included regarding this extremely important phase of hospital growth

past few years and find that the going is hard.^{4, 5}

Some think that the increase and extension of hospital services should proceed along several lines and should not only include more and better service to the ambulatory, the chronic and the convalescent sick, but should also embrace hospital controlled, home nursing of the sick.² In this connection, it is brought out that the convalescent sick could be more economically cared for in an institution geared down to a simpler scope of operation than that found in the large general hospital where the fixed operating overhead is necessarily high. If the large general hospital is to succeed in cutting the cost of care for convalescents, it must isolate and departmentalize the service in such a way that the overhead operating expenses of the department will be lower than the average in the rest of the hospital.⁶

There is a great need for convalescent institutes to which patients might be transferred after their period of acute care in the hospital, the cost of proper convalescence thus being greatly reduced. Many of these cases could be better cared for in a convalescent institute since most general hospitals do not have grounds or other desirable facilities for good convalescent care.⁹ Whether it is available in a department of the hospital or a separate institute, good convalescent care at low rates would reduce the inclination of patients to return home the fourth or fifth day after an oper-

ation to cut down the cost of hospitalization.⁶

It is also pointed out that although many general hospitals are operating at occupancies lower than 50 per cent, there seems to be no active tendency to give particular attention to the need of the convalescent patient.⁹

Several suggest in effect that the staff or courtesy staff of hospitals be increased so that facilities for the treatment of ambulatory sick may be more broadly employed by staff physicians if not by general practitioners outside the staff.^{7, 10} In this way consulting services of the hospital, electrocardiograph, x-ray and laboratory facilities might be more profitably used by all qualified physicians in the community at reduced cost to the patient. Certain hours could be set aside during which the general practitioner might accompany or send his patient to the hospital to obtain these services.⁷ Many leaders are convinced that the problem of medical care can be solved through closer relationships of this kind, and that the more completely the hospital develops the ideals of group practice (for which after all it essentially exists), the greater its public service will be.¹⁰

Still another administrator looks at the whole problem from the point of view of distribution of our capital resources in all hospitalization. When we look at the combat of all disease as a matter of proper organization of man power and materials, is it not true that our material facilities are almost exclusively engaged with acute disease?¹¹

Distributing Capital Resources

Under these circumstances our immediate problem is that of distributing our capital resources over a wider front in our war on disease.¹¹

There is only one way we can do this and that is to increase all kinds of ambulatory and outpatient services which might be rendered by the hospital. Furthermore, doing this will employ more of our man power and give our men better facilities with which to work. It will decrease the cost of medical care and ought to increase greatly the volume of medical and hospital services used. It will also greatly reduce the duplication of materials used in the combat of disease and therefore make possible further reductions in the cost of medical care.¹¹

Finally, we come to our last question — how can the public be better educated to the more extensive use of hospital services by the medical profession? What shall be done to teach the importance of hospital service?

In any discussion of this kind it is almost self-evident that the public needs constant education concerning the essential importance of adequate

hospital support.¹² All seem to agree that the facts of hospitalization should have wide publicity and that such publicity could be carried on to great advantage for the hospitals.^{4, 13, 14} Individual hospitals, hospital councils and state and national associations are convinced of the necessity of adequate publicity.¹⁵

Education of the public generally with regard to the financial needs of the hospital and the place of the hospital in the community is deemed necessary. An organized public relations program is vital in obtaining organized support for the hospital.^{3, 16}

Aloofness Must Be Abandoned

One respondent believes that hospitals must tell the public what they have to offer and what they are doing to put hospital services within the reach of all classes. The hospital's traditional attitude of aloofness must be abandoned, yet a plunge into sensational advertising should not be taken. Results will be obtained through cooperation among all hospitals in putting on a high grade program of educational publicity, so handled that it will receive the sympathetic interest and understanding of the whole public.¹⁷ In this connection, it was held that hospitals need to teach as well as heal the public.^{6, 18}

Another takes the whole idea of distinguished service back to community cooperation and publicity calculated to educate the public.¹⁹

Suggested means of proper publicity are numerous. Food clinics in which the public may be educated regarding dietary problems, health talks to school children, radio health talks, health columns in the newspapers, mothers' clubs for those who obtained maternity service in the hospital, and distribution of literature on the care and feeding of babies are considered effective means of publicity.²⁰ Others suggest lectures to grade, high and normal school students by nurses, dietitians and accountants, all to be well illustrated by graphs, charts and pictures.²¹ Tours for school children through certain departments of the hospital are suggested, including the power plant, the laundry, the refrigeration plant, the kitchens, the emergency lighting plant and a demonstration of ambulance and ambulance service.²¹ Dietetic lectures for parent-teacher associations, nutrition lectures to Red Cross units and food lectures to those in charge of nursery schools are also suggested.

In one place it is reported that as a result of these lectures a series of public health talks and education lectures have been organized by the hospital council. These are to cover the needs of the community from a medical and hospital point of

view and, correspondingly, the need of cooperation between the hospitals and the community.¹⁸

One publicity feature cited provides a good example of how useful things and services may be turned to good account in gaining favorable notice for the hospital. A courtesy card is issued to persons in the community who have visited the hospital or otherwise had some contact with it. This card carries the person's name, his business and residence phones and addresses, and the name and address of his physician. It also carries other information and serves as an identification card, but is especially useful in obtaining proper medical and hospital care in case of serious accident.²¹

Cheap Publicity Doesn't Pay

Together with the enthusiasm which exists for hospital publicity in many quarters, there are warnings that good publicity is never cheap publicity and may involve remaking some of our ideas about all publicity. It is especially emphasized that when a hospital renders distinguished service (in the sense implied in these articles) a favorable impression can be made without resorting to those cheap methods often used to place the hospital before the eyes of the public.²³

Again it is pointed out that while many think education of the general public to be essential, in reality, education of those on the board is sometimes more needed and more difficult.^{13, 24} We cannot have distinguished service in our hospitals (unless under unusual management) except by the active support of trustees. Until we have a live coming together of trustees many of our hospital problems will remain unsolved. That is why hospital councils must include trustees.²⁴ Hospitals need to be publicized and the public educated, but boards of trustees should be educated first.¹³

A yearbook for trustees is proposed in this connection. Such a book, centrally published, might contain accurate, nontechnical treatment of all important advances both real and suggested and discussions of the fundamental problems that have arisen in the hospital field within the year.

It is suggested that since public money builds and supports our hospitals the public should hold hospitals to account through impartial investigation and surveys of their functions in a given community.²⁵

It has been stated that voluntary hospitals will make their way from now on in accord with their capacity to analyze the needs of their communities and devise methods of meeting those needs.²⁶ This analytical work and planning are but one function of a good public relations program. Publicity without this approach to problems is liable to be rather useless if indeed it is not a boomerang.

The things that good publicity and good organization can do are numerous and a better understanding of what is involved in publicity and promotion will bring success.¹⁰

The MODERN HOSPITAL is sincerely appreciative of the cooperation given in these articles by men and women throughout the country. Almost every shade of opinion and every section of the field have been represented in the suggestions made. It is hoped that these suggestions will promote distinguished service in our hospitals.

The suggestions themselves fall pretty generally into four categories, and they might be briefly summarized as follows:

1. Hospitals should do away with the "walled town" idea. They should strive to cooperate to the utmost among themselves and with other social agencies and thus integrate themselves with the community.

2. The cost of hospital service must be reduced, if possible, and brought within reach of moderate and low incomes. Group hospitalization seems to offer the best means of doing this.

3. Ambulatory and out-patient services of the hospital must be extended and increased so that hospitals may serve a larger percentage of the sick.

4. We ourselves, our boards of trustees, and the public generally need knowledge of what the hospital does and can do, and how it can be more effectively used. This calls for rational and intelligent publicity based on sound research and planning.

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- ¹²Charles H. Bardeen, M.D., dean, school of medicine, University of Wisconsin, Madison, Wis.
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Randolph Hospital Is Community

YOU will find it where every efficient life-saving station should be found — directly on the danger line. This particular danger line in Randolph County, North Carolina, runs along the paved state highway leading into the main street of Asheboro, a town of some 5,000 to 6,000 population located in the center of the state.

You will find in Randolph Hospital a true community project. A bronze plate inside the vestibule attests to this fact with the information that the building was erected with donations from the citizens and friends of Randolph County, the Town of Asheboro and the Duke Endowment. Further evidence is revealed by the names of donors appearing on the doors to every room in the building with the exception of the kitchen and storeroom. Individuals, business enterprises and churches are well represented.

The hospital even has what might be termed a branch business office in town. You reach it by continuing along the main street from which a right turn leads directly to the entrance of one of the large hosiery mills which constitute a major share of the industry of that community. Its president, D. B. McCrary, is also the hospital's president, his business office the hospital's business office, so closely are the two related.

Not infrequently, visitors to the mill come on no errand of business whatsoever. They are persons seeking hospitalization, who are invited to discuss frankly their financial status with Mr. McCrary and arrive at some equitable adjustment of the indebtedness they are about to incur.

By **RAYMOND P. SLOAN**

Associate Editor, *The MODERN HOSPITAL*

The chances are this hospital president knows the situation already. If not, he proceeds to investigate with the assistance of Miss Bulla, his secretary, who is as much a hospital woman as though she herself lived within its walls. It is not every institution that can boast such well conducted midtown business headquarters.

This cooperation facilitates hospital procedure at the hospital immeasurably. A president who is not a layman but a hospital man in the true sense of the word is one of the hospital's chief claims to distinction. Anne Reece Quinn, superintendent, proudly explains that hardly a day passes without a visit from Mr. McCrary. He knows the hospital thoroughly from top to bottom and frequently the name of each patient. He in turn interprets the hospital's services through the officers and board members of the Randolph Hospital Corporation to the entire community.

This institution is fortunate in having for its secretary and treasurer N. M. Cranford, who has handled the records and finances since the first committee was appointed to secure funds and build the hospital.

Shortly before the formal opening Miss Quinn and her assistants, Viola Lyon and Bertie Scarborough, took charge. They have associated with them a corps of graduate nurses of the very highest type. The hospital corporation, as well as the patients,



Life-Saving Station

greatly appreciate the fine work they are doing.

The need of a hospital to serve Randolph County became apparent some years ago. At that time the nearest hospital accommodations were at High Point, some twenty-five miles distant.

Randolph County, it might be explained, comprises 772 square miles or 513,920 acres. Its population for the year 1930 numbered 36,259 which figure has considerably increased since that time.

The Piedmont region is not to be confused with the so-called "poor" section of the South. Located on a high plateau between the foothills and the central plains, its soil is fertile, producing small grain, hay, corn, cotton and tobacco. Its textile and hosiery mills hum with activity and numerous other industrial pursuits provide substantial employment. In consequence, its people are hard-working and thrifty. Less than 15 per cent of the population is colored and less than three-tenths of 1 per cent is foreign born.

The idea of a hospital to serve this area first took definite form in the spring of 1928 when the aid of the Duke Endowment was enlisted and the cooperation sought of such local organizations as the Chamber of Commerce, the Kiwanis Club, the Rotary Club, members of the town council, with a large number of prominent citizens from various sections of the county.

It was felt from the start that the hospital should be a community project with everyone given an opportunity to contribute. The town of Asheboro proceeded to authorize the issuance and sale at par of \$25,000 in hospital bonds. These bonds were

sold and the proceeds turned over to the building committee. Next a direct appeal was made to people in the town and county, former residents and friends.

The result was gratifying. Not only was the required amount of \$25,000 secured, but an additional sum of \$15,000, making a total of \$65,000, received from private subscription and bond issue. To this a similar amount was added by the Duke Endowment.

The result is a completely equipped hospital of fifty beds possessing every modern facility, also a nurses' home providing accommodations for fifteen graduate nurses and a small house for other help. The total cost, including the four acres of ground on which the hospital stands, its landscaping and other details amounted to about \$130,000.

Randolph Hospital has been described as a community life-saving station, its organization and operation closely allied to the life of the territory it serves. It is now interesting to note precisely the type of life-saving station it was possible to establish at an expenditure of \$130,000.

Its location could not be better — on the main highway but set back sufficiently to ensure quiet and relief from dirt and disturbing odors. The ground slopes upward from the street level toward the center so that the building is perched on the highest point, providing an abundance of light and air on all sides.

Modern—but Not too Modern

There is just enough of the modern note in its design to mark it as belonging to the present era. Shaded buff to brown face brick forms the exterior finish trimmed with cast stone. Its three floors are fireproof throughout.

The main entrance which is on the second floor is reached by a flight of stone steps. In addition to the main lobby, office and waiting room, six private rooms are on this floor, with three wards of three beds each. Bed occupancy can be increased by placing additional beds in the solariums provided at each end of the building.

A brief inspection of the third floor reveals thoroughly up-to-date surgical and maternity suites centered at the north end. Included in these sections are major and minor operating rooms, sterilizer room and doctors' and nurses' dressing rooms. All equipment is of modern design.

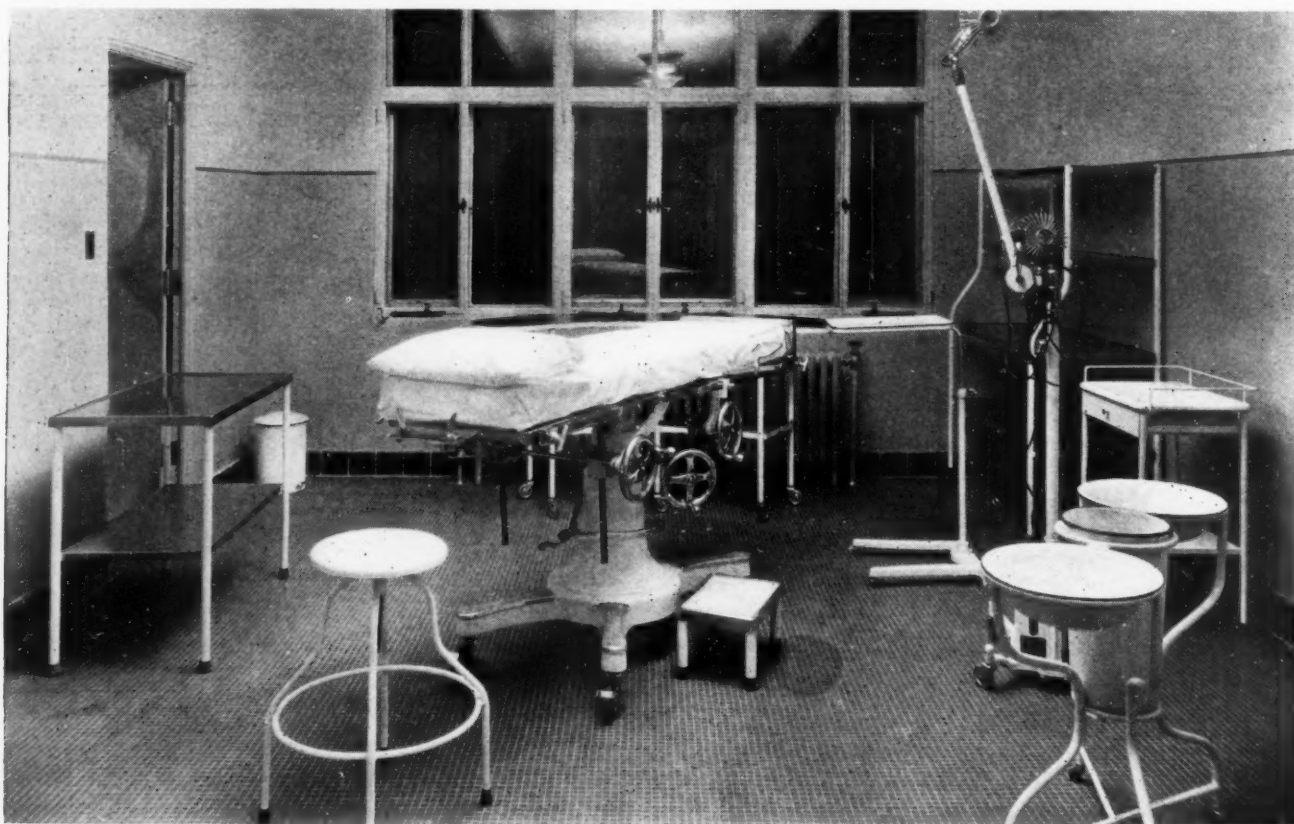
The delivery room and nursery comprise the maternity suite. Facilities are provided for seven babies, but there is room for three more should occasion demand. This floor also has five private rooms and one four-bed ward. The children's ward is also on this floor with a capacity of three cribs.

All patients' rooms and wards have lavatories



Private rooms are simple in their furnishings but extremely comfortable. Telephone connections and radio outlets are provided in many instances. All the rooms have lavatories and six of them have connecting baths.

The north end of the third floor is given over to the maternity and surgical suites comprising major and minor operating rooms, sterilizer room and doctors' and nurses' dressing rooms. One operating room is shown below.



and six of the private rooms have connecting baths. Each floor, too, has a patients' bath, a utility or workroom, a diet kitchen and ample linen closets. The hospital is wired throughout for radio, and telephone connections are provided in a number of the private rooms.

The next visiting point is the first floor. Here is found the colored section. This has three wards containing seven beds with room for two additional, if necessary. This part of the hospital also has its own utility room and nurses' chart desk.

The rest of the first floor comprises the usual hospital set-up of emergency room, x-ray room, pharmacy, laboratory, out-patient department, supply, storage and refrigeration rooms, kitchen and dining room, also a bedroom for an orderly or watchman.

So much for the physical layout of this commu-

nurses in all are employed in addition to Miss Quinn and her assistant. A colored graduate nurse supervises the colored section. Then there is a technician in charge of laboratory and x-ray work, a cook and kitchen helper, a boy for the halls, a maid and an engineer.

This, of course, is recognized merely as a skeleton force which will be augmented as the hospital's services expand. It must be remembered that it is just three years ago that the building was opened.

During the first two-and-a-half years, 1,328 patients were treated, 552 of whom underwent major operations. Approximately 400 others underwent minor operations. The total number does not include maternity cases of which there were about 300. Much of its departmental work and clinical procedure is still in the process of organization.

Private accommodations range from \$4.50 to \$7

At each end of the second floor is a spacious solarium furnished with easy chairs and lounges comfortably upholstered in leather.



nity life-saving station. The next step leads to a brief insight into its methods of operation.

The Randolph Hospital, Inc., is a corporation belonging to the people who have made it possible by their gifts. It is made up of twenty-one members who meet once a year. From this group officers are elected and also nine directors who meet twice a year. The president appoints an executive committee of five to keep in actual touch with the hospital operations and report to the other two bodies, so the members of this committee find it expedient to meet approximately every month.

The staff is composed of all the doctors in Randolph County. It is an open staff with the exception of major surgery. This department, as well as the professional supervision of the hospital as a whole, comes under the jurisdiction of the staff of the Burrus Clinic at High Point, N. C.

With an average occupancy of eighteen or nineteen patients, it is essential that each employee cover as many duties as possible. Seven graduate

a day, but approximately 50 per cent of the work which the hospital performs is free. The cost per patient per day is figured at \$3.68. Help from the Duke Endowment and funds appropriated by the county authorities assist in meeting expenses, the difference being made up by staunch friends and supporters.

And this brings us back to the original description of Randolph Hospital as a community life-saving station, boasting a president who gives it daily personal supervision and interprets its services in the everyday language of the countryside. It is all summed up in the following paragraph:

"Let the citizens of Randolph County feel that this is their hospital, built by them and their friends and maintained for their benefit. May they encourage and support it to the end that it will be a real and valuable service to the county. It should be a factor in preserving the health and prolonging the life of our people, thereby making a happy and prosperous community."

Editorials

Fairness to the Nurse

IS THE hospital profiteering on the economic distress of nurses by wrongfully reducing salaries or by offering to general duty nurses a paltry recompense with board, hoping that they will accept such humiliating positions because they are in dire financial need?

Throughout the field it is suspected that not a little unfairness is being shown to these trained professional women. Here and there but a pittance is being paid as a salary and the attitude of the trustee has been that it is better for a nurse to earn her board and laundry than to be without any income at all. Were the nurse not a member of a dignified profession and had she not contributed to the welfare of society in general, such an attitude might be understandable. But, to take advantage of a nurse's financial want by offering humiliating conditions which will merely enable her to work in order to exist is not fair play. If educational advantages are offered in addition to her salary and board these promises should be taken seriously and religiously fulfilled.

After all, the nurse has not only her physical body to maintain but also that which is of even greater importance to her—her self-respect. Profiteering at the expense of the nurse is to be condemned.

Our Public Relations Problem

TWO decades ago when hospitals were engaged in extensive building operations, The MODERN HOSPITAL joined with other agencies in pointing out the imperative need for a careful survey of needs before new building is undertaken and the desirability of utilizing adequate consultant service on the architectural planning of the buildings.

These lessons were, in general, well learned. It is now rare for any important building project to be started without some sort of a survey of hospital needs being made, often, it must be admitted, not as critical and constructive a survey as should be made. It is even rarer for an important hospital to be built without adequate consultation either with recognized, qualified hospital consultants or with architects with extensive experience able to grasp the service problems that must be met.

Today, our fundamental problem is a different one. Commissions, committees and conventions

have studied it and discussed it, in the main intelligently and sincerely. The problem is fairly clear. It is the problem of filling the hospitals we have built — using their material facilities to better advantage. The base of hospital service must be broadened. A greater number of physicians must be made more effective in their practice by the better use of the available plant facilities of the hospital. We must make our capital plant more productive. The American public must be educated to make more effective use of hospitals. The public as a whole can afford more nearly adequate medical and hospital service right now, if they only knew it.

What are we going to do about it? Unless we ask ourselves that question we shall probably not do enough about it or what we do will be done far too slowly. The problem is twofold — first, research into the work of hospitals and the needs of people and, second, planning that work so as best to meet those needs. This research and planning should be used as a foundation for the organization of the hospital. The promotion and publicity which are usually necessary to carry the plans into effect should fit in completely with the research and planning. Without such publicity and promotion, a large part of the value of the research will be buried. The entire program must be carried out with rigorous intellectual honesty. A competent, experienced director is essential because pseudo-surveys and poorly articulated planning will never do the job.

Ultimately a program of this kind should be organized on a communitywide basis. Before this is practicable, however, individual hospitals must be brought to a high level of performance so that this cooperation may have a solid foundation.

Godfathers Wanted

THERE is much confusion in the hospital world because we do not use the same terms for the same thing. The active discussions regarding the relation between hospitals owned and operated by local, state or national governments and hospitals under the auspices of nongovernmental agencies illustrate the case.

Arguments take place, with one set of people calling the government hospitals "public hospitals" and the nongovernmental, "private"; other people object to the word "private" because they think that implies a proprietary hospital, that is, one established for private profit. The latter group point out that many nongovernmental hospitals do an immense amount of public service and do not wish to confine the term "public" to the governmental institutions. The word "voluntary" current in England as applying to the nongovern-

mental, nonprofit institutions, has been considerably used in this country in the same sense. Other people like the name "community hospitals" for the voluntary, nonprofit institutions which accept all social classes as patients. Others point out that, particularly in smaller cities and towns, the local municipal or county hospital often accepts all classes and is a community hospital if there ever is one.

The MODERN HOSPITAL would like to secure opinions and suggestions from the hospital world as to the most desirable terminology. Specifically, what is the best name for the nongovernmental, nonprofit hospital? Should it be called "voluntary," "community," "public" or just "nongovernmental"? Incidentally, how shall we distinguish by a simple terminology the nonprofit, nongovernmental hospital and the nongovernmental hospital which is on a proprietary or profit basis?

We ask for written suggestions. We shall publish the gist of worth while communications and hope to incorporate the consensus of opinion in the September issue. Will prospective godfathers kindly take their pens in hand?

A Food Specialist for the Out-Patient

THE presence of the trained dietitian in the hospital personnel is too often taken for granted. She is but a part of a forward movement which has taken place in the last few decades relative to a better understanding of the rôle food plays in the treatment of disease and in the maintenance of health. Few realize that a half century ago a physician was unable to secure any assistance in the filling of food prescriptions and indeed but few physicians appreciated in any measure the necessity for this service.

Receiving their stimulus from English schools, the New York and Philadelphia cooking schools were pioneers in home economics in this country. As a natural result of this movement there came the instruction of pupil nurses and medical students of the Women's Hospital and Women's College Hospital as early as 1879. These classes were carried on without the hospital and were the direct expression of the belief, which even today some seem to doubt, that the nurse should be able to prepare a nutritious yet attractive tray.

In few cities, however, are there facilities for the scientific preparation of diets for the out-patient of small means. The opulent may engage the services of a dietitian for the dietetic treatment of nephritis or diabetes. For those less prosperous usually only the services of the hospital

dietitian are available. It is surprising to note that even now so many institutions which are pleased to call themselves modern are endeavoring to carry on their work without the services of a food specialist.

And yet, there is a dangerous corollary to the development of the dietitian. Food quacks are rampant. The radio reverberates with their blatant promises of relief of sickness. The more radical and ridiculous the diet the more popular it seems to be. But the trained dietitian carries on and with the understanding support of the medical profession she will continue to render an important contribution to the care of the sick.

Childish Effrontery

RECENTLY a well known and reputable manufacturer of hospital supplies refused to purchase advertising in a pamphlet being published by a hospital. In a few days he received the following letter from the hospital:

"Please check us off your mailing list as we do not intend to purchase any more supplies from your concern due to the lack of cooperation on your part. . . . We do not want to be bothered with any further advertising matter, catalogues, price lists or visits of salesmen from your concern."

Such childish effrontery in violating ethics and good taste is fortunately rare in the hospital field. Obviously no national manufacturer can assume responsibility for support of the several thousand local hospitals of this country. Ironically enough, this particular manufacturer and his personnel have been most generous in supporting their local hospitals — which is certainly all that may properly be requested of them.

The hospital administrator who has thoroughly analyzed the considerations involved and who is truly ethical will not only never stoop to such a low level but will never solicit donations and will be very careful about accepting valuable gifts from manufacturers and supply houses, except, of course, samples for test under hospital conditions.

Radio Therapeutics

HOMESICKNESS is a serious ailment. A longing for the day of return to his home is uppermost in the mind of every patient in the hospital. This dread of abandoning familiar surroundings, even temporarily, for a period of treatment in the hospital is the factor that prevents many a needy patient from enjoying to the full the institution's humanitarian services.

Occupational therapy, the hospital library and more recently the radio are therapeutic agents aimed at the relief of nostalgia. Of these the radio probably plays the most important rôle for good because of its general appeal to convalescent patients. To one who has observed a patient with lowered morale and weakened body and spirit endeavoring bravely to fight this home longing, the diversion which the radio offers can bring no surprise. Instead of radio equipment being considered as a luxury in the hospital it has now become almost a necessity. Bringing diversion and contentment to the mind of discouraged and distressed patients it has times without number enabled the physician more thoroughly and permanently to bring about a cure.

The hospital radio brings, then, to an atmosphere of mental and physical distress much sunshine and much happiness. It is surprising that broadcasting companies have not recognized the need of almost a million patients daily residing in the country's hospitals by offering special program hours for their benefit. The radio if properly controlled has real therapeutic possibilities.

A Survey of Medical Service

EACH year the hospital meticulously inventories its physical possessions. Regularly it does or should publish a statement relative to the scientific work which it performs. The annual report from a scientific angle consists of long lists of diseases with a classification of such facts as sex, age, color and marital state of patients represented by the diseases listed. A mention of complications and morbidity among obstetric patients or of errors in diagnosis or technique in the medical or surgical wards is conspicuous by its absence.

A thorough medical survey of the work of the hospital is of even greater importance than a physical inventory or the usual statistical annual report. The former is merely a matter of good business. The latter finds a dusty resting place on a little used bookshelf. A scientific, functional survey is life-saving. The feelings of surgical staff members might be slightly bruised by such an evidence of fallibility on their part but what of this if human beings are benefited thereby?

The MODERN HOSPITAL recommends that each institution carefully study its scientific output as the year concludes and that such a study include a survey of infections, surgical accidents, errors in diagnosis as shown by postmortem examinations and morbidity and mortality statistics. If a staff member cannot withstand this type of scrutiny then he should be replaced.

Written by the Staff

THE scientific instincts of a hospital staff can be rather accurately measured in terms of its contributions to medical literature. The library of an institution may be plenteously supplied with the recorded observations and investigations of others, and yet the scientific zeal of its own staff may remain at a low ebb.

To require of each major staff member the preparation of at least one paper a year and one appearance before a local or national medical society ought not to be necessary. Yet if hospitals were to adopt and enforce such a rule, it would exert a salutary effect on their general medical morale.

Moreover, it would be a splendid practice for each institution to collect and bind the reprints representing staff contributions over a period of years and to place this volume in the hospital library. Such a recognition by the board of trustees of the importance of the intensive scientific study and report of patients under the care of the staff would be stimulating to the younger generation of practitioners. The sum total of recorded medical experience can grow as it should only if each medical activity annually contributes thereto.

A Women's Visiting Committee

ALL hospital executives are not of one mind in regard to the advantages of having women on the board of trustees or of a women's visiting committee. Some contend that a women's committee is inclined to meddle in matters of housekeeping and to fail to adhere to the proper routine in their contacts with members of the hospital personnel. Such a committee, it must be granted, the superintendent sometimes finds difficult to manage. This is usually due to unfortunate selections in its membership or to the lack of organizing ability in its chairman.

Women have contributed much to the hospital and its work. They are capable of interpreting the hospital to the community as can no other group. They are usually indefatigable in their efforts to increase its usefulness. A women's visiting committee has on more than one occasion stimulated and maintained the community's interest and respect for its hospital. In suburban and rural institutions groups of women scattered throughout a county have created a stability of support which was effective in maintaining the hospital's work.

Let not the advisability of the establishment of such a group be dismissed by a mere shoulder shrug. The support of public-spirited women has great potentialities for good to the hospital.

PLANT OPERATION

Conducted by John C. Dinsmore and R. C. Buerki, M.D.

Reclaiming Silver From X-Ray Hypo

NOT long ago a hospital in the Middle West sold, for just a little less than \$200, enough dry x-ray sludge to fill two five-gallon cans. In general, its experience has been that about 9½ pounds of dry sludge is salvaged from 60 gallons of fluid. This material has a sale value of about \$2 a pound or \$19 from the 60 gallons. The cost of reclaiming the sludge from 60 gallons of fluid is about \$1.15 for material and about \$2 for labor—a total of \$3.15, leaving a net of \$15.85.

Several methods are used in reclaiming silver from x-ray solutions. The following statement is taken from the transactions of the Society of Motion Picture Engineers No. 26. The material is prepared by J. I. Crabtree and J. F. Ross, research chemists of the Eastman Kodak Company. They report four methods which are as follows: (1) precipitation with sodium sulphide; (2) precipitation by means of zinc; (3) precipitation with sodium hydrosulphite; (4) electrolytic methods.

The Sulphide Method

The sulphide method consists essentially of adding sodium sulphide or liver of sulphur to the fixing bath, when the silver is precipitated as silver sulphide. The efficiency of the method is high owing to the fact that silver sulphide is the most insoluble of all the common salts of silver.

The objection to this method of precipitation is the offensive odor of the hydrogen sulphide evolved if the fixing bath is acid, the acid causing decomposition of the sodium sulphide. Since fumes of hydrogen sulphide affect sensitive photographic materials, thus causing fog, such gases must not be evolved if there is a possibility of their entering the laboratory. To prevent this, the bath may be made alkaline with caustic soda before adding the sodium sulphide.

This process of neutralization adds considerably to the expense of the process, but is absolutely necessary if precipitation is carried out in the laboratory building. If the recovery plant is

remote from the building, neutralization is not necessary, but even in this case in a populated district the objectionable odor of hydrogen sulphide might be termed a public nuisance, and neutralization would be necessary. The following instructions for precipitation of silver with sodium sulphide include the neutralization of the bath, but if the odor of the hydrogen sulphide is not objectionable, neutralization should be omitted.

Place the exhausted hypo in a suitable container, such as a wooden tank, elevated slightly from the floor to facilitate draining. Place a strip of red litmus paper in the solution. If it remains red the solution is acid, but if it turns blue the solution is alkaline. Most exhausted baths are slightly acid, and they should be neutralized with a solution of caustic soda (sodium hydroxide) prepared by dissolving commercial caustic soda in cold water in the proportion of 2 pounds to a gallon (900 grams to 4 liters). The solution becomes hot during mixing. If hot water is used for dissolving the solid chemical, so much heat is evolved that the solution is apt to boil with explosive violence. Caustic soda is corrosive, and care should be used in handling both the solid chemical and the solution. Then

add the caustic soda solution to the hypo in the proportion of 1 ounce per gallon of hypo, stir well and test with litmus paper. If the solution is not alkaline, continue to add the caustic solution until a strip of litmus paper turns blue. Then add about ¼-ounce of the caustic solu-

tion per gallon (1½cc. per liter) in order to ensure distinct alkalinity.

As the neutralization with caustic soda progresses, a light colored flaky precipitate will form if the fixing bath contains an alum hardener. This precipitate generally dissolves when the bath becomes distinctly alkaline. The disappearance of this precipitate is a good indication that the bath is sufficiently alkaline, but the litmus paper test is more satisfactory. To each gallon of hypo solution add 1 ounce (30cc.) of sodium sulphide solution prepared

by dissolving the fused salt in the proportion of 2 pounds (900 grams) per gallon (4 liters) of hot water. This should be prepared away from the dark room because hydrogen sulphide gas is liberated on dissolving the sulphide.

Stir the solution thoroughly and test for the presence of silver by filtering a small volume and adding a little sodium sulphide solution to the clear filtrate. Any precipitate which forms, indicates that silver precipitation is incomplete. It is necessary to continue additions of the sulphide solution to the bath until this test gives a clear solution and no brownish black precipitate forms.

The presence of an excess of sulphide can also be determined by means of strips of test paper prepared by soaking strips of blotting paper in a 10 per cent solution of lead acetate or lead nitrate. The strips may be used either wet or dry. In making the test, dip a strip in the solution and remove immediately. If the paper turns uniformly black, there is an excess of sulphide in the solution, which in turn indicates that all the silver has been precipitated.

Allow the bath to stand overnight, so as to permit the silver sulphide sludge to settle completely and drain off the clear liquid by means of the draining spigot or syphon. In large motion picture laboratories it is customary to have several storage tanks, some of which are being filled with exhausted hypo while the silver sulphide sludge is settling in others. Several precipitations are usually carried out in one tank before the silver sludge is removed. In order to prevent the possible loss of silver contained in the supernatant liquid, this is drained into a second or third settling tank from which it is passed into the sewer.

Handling the Sludge

Small quantities of sludge may be dried by exposing them to the air in flat trays. Moderately dry sludge may also be mixed with sawdust for shipping purposes. The sludge is removed manually from the large precipitation vats by means of shovels and packed in watertight barrels or dried on trays in a drying oven.

When submitting silver residues, a fixed assay charge is made regardless of the quantity shipped. It is important, therefore, not to submit the residues to the refiner until a quantity has accumulated that will make the shipping and refining charges but a small percentage of the value of the silver recovered.

The dried sulphide sludge consists mainly of silver sulphide and hypo, the quantity of the latter depending upon the thoroughness of draining. If the precipitation is carried out in a solution which is only slightly alkaline, the sludge will contain compounds of aluminum, but these will not be present

if the bath was distinctly alkaline before precipitation. If precipitation is carried out in acid solution, the sludge will contain free sulphur. The sludge from a chrome alum fixing bath will also contain chromium hydroxide if it is made alkaline before recovery. Various silver sulphide sludges tested contained from 40 per cent to 70 per cent silver.

The Zinc Method •

Zinc is an efficient material for displacing silver from solution. Precipitation with zinc has a distinct advantage over the sulphide method in that it is not accompanied by the liberation of disagreeable or harmful gases.

The zinc may be employed in three forms—either as zinc dust, granulated zinc or sheet zinc. Of these, only zinc dust is of value for large scale recovery, because the rate of precipitation of the silver with both granulated and sheet zinc is too slow.

Although zinc dust will precipitate the silver satisfactorily in either acid or alkaline solutions, the best results are obtained if the solution has an acidity equivalent to 1 ounce of acetic acid per gallon (7cc. per liter). For rapid recovery it is also necessary to agitate the bath frequently. When the recovery bath is neutral, a foam which contains silver is formed on top of the solution, so that some silver is apt to be lost on draining.

The method outlined below is the most efficient although possibly not the most economical. The adjustment of the acidity by means of acetic acid can be omitted. For other conditions of acidity, the recovery might require a longer time and also more frequent stirring.

Place the exhausted hypo in a suitable container, such as a wooden tank which is elevated to permit of easy draining, and test the acidity or alkalinity of the solution by means of litmus paper. If the bath is acid, a strip of red litmus paper will remain red when placed in the solution, but blue litmus paper will turn red. Most exhausted baths are acid, but if the tests indicate that the bath is alkaline it should be made acid by adding a sufficient quantity of glacial acetic acid. In the case of the bath being acid (or after it has been made acid), add a further quantity of glacial acetic acid in the proportion of $\frac{1}{2}$ -ounce (15 cc.) to each gallon (4 liters) of hypo. The bath is then ready for precipitation of the silver.

Slowly add the zinc dust to the bath with vigorous stirring in the proportion of $\frac{3}{4}$ -ounce per gallon (5 grams per liter). After all the zinc dust has been added, stir the bath for two or three minutes more and then allow it to stand over night. Unless the fixing bath was heavily loaded with silver, the precipitation will be complete after standing for sixteen to twenty-four

hours, but it is well to test for completeness of precipitation. Remove a small volume of the clear hypo and place a bright strip of copper in it. If after standing one minute the copper is covered with a silvery coating, the silver has not been completely precipitated, but if the metal simply darkens slightly and does not take on a silvery appearance, the silver has been completely precipitated.

Another method of testing for completeness of precipitation is by means of sodium sulphide. Take 1 ounce (30 cc.) of the clear bath, add $\frac{1}{5}$ -ounce (6 cc.) of glacial acetic acid and about the same volume of a 20 per cent sodium sulphide solution. The formation of a dark brownish black precipitate indicates incomplete silver precipitation, while the lack of a dark precipitate indicates complete precipitation. In case precipitation is not complete, add zinc dust in the proportion of $\frac{1}{4}$ -ounce (8 grams) per gallon (4 liters) and stir. After it stands a second day, precipitation will be complete.

Drain away the clear (or slightly opalescent) liquid by means of the draining spigot or a syphon. The remaining silver zinc sludge should then be dried in the manner used in the sulphide method.

Composition of Sludge

The final dried sludge from an acid recovery bath contains silver (probably sulphide), free zinc, and sodium thiosulphate, the amount of the thiosulphate depending upon the thoroughness with which the sludge has been drained.

The sludge from the neutral recovery bath will contain silver (sulphide), free zinc, zinc hydroxide, basic aluminum sulphites and thiosulphate. In an alkaline recovery bath, the basic aluminum sulphites remain in solution, but the percentage of zinc hydroxide in the sludge is greater. The aluminum compounds will not be present in any case unless the original hypo bath contained an alum hardener.

The percentage of silver in the sludge is dependent on the silver content and the acidity of the hypo bath, which control to a large extent the quantity of free zinc present in the sludge. The controlling factors are so numerous that it is difficult to state a probable silver content, but this generally falls between 15 and 40 per cent silver for the dried sludge.

From an economic standpoint there is little difference in the cost of chemicals required for the zinc or sulphide methods. For recovering the silver from 100 gallons of bath by the sulphide method, the cost wholesale of the sodium sulphide is \$0.30 and that of the caustic soda also \$0.30. If the bath is not neutralized, the latter cost is eliminated.

With the zinc method the costs are \$0.40 for zinc dust and \$0.30 for acetic

acid. The addition of acetic acid is not essential, but in the absence of this additional acid the rate of precipitation is not so rapid. The labor costs by the zinc method are slightly greater, since it is necessary to stir the bath at intervals either manually or by means of a mechanical stirrer. Also, the precipitated silver does not settle quite as rapidly, since it is apt to remain in suspension as a result of effervescence caused by the evolution of hydrogen produced by the interaction of the zinc and acid.

Sodium Hydrosulphite Methods

The use of sodium hydrosulphite to recover silver from used hypo baths was first described in "A New Photographic Silver Removal Process" by A. Steigmann in *Kolloide-Zeitschrift* 28: 175, 1921.

The appearance of the precipitate (obtained in alkaline solution), which is black and very dense, would indicate that it was metallic silver, but analyses of some of the washed precipitates showed that they contained both silver and silver sulphide. Tests with this method showed that the bath must be made alkaline and the precipitation carried out at a temperature of 50 to 60 degrees C. (120 to 140 degrees F.) for most efficient results, although by using a mixture of sodium hydrosulphite and sodium sulphite it is not necessary to make the bath alkaline. When the precipitation is conducted at ordinary temperatures, one to two days are required to precipitate the silver.

The chief objection to methods of recovery with sodium hydrosulphite or its derivatives is the relatively high cost in comparison with the zinc and sulphide methods. Precipitation is no more complicated, while the silver precipitate obtained is more compact than that given by any other precipitation process. Proponents of this method have claimed that the high cost of the hydrosulphite is offset by the fact that the fixing bath is rejuvenated. Since it is inadvisable to attempt to utilize a fixing bath after recovery by any of the methods described later, this factor is of no importance. Unless the present price of hydrosulphite can be reduced, this method does not possess sufficient advantages over the zinc or sulphide methods to justify its general adoption.

Electrolytic Method

It is a difficult matter to electroplate satisfactorily the silver out of an exhausted fixing bath in the metallic condition by the usual methods of electroplating. If the voltage is carefully regulated so that the potential between the electrodes is around 0.7 volts, metallic silver is deposited, but only slowly. If the voltage is raised above 1.0 volt, a sludge of silver sulphide forms at the negative electrode and throughout the solution, due to a reac-

tion between the hydrogen liberated at the cathode and the thiosulphate ions.

Attempts were made to precipitate the sulphide at the cathode and retain it there by the use of a porous cup, but the method proved unsuccessful. More sulphide is formed than is used up by the silver at the cathode, and this excess sulphide diffuses into the main bulk of the solution and precipitates silver sulphide.

An investigation into the costs of electrolytic precipitation revealed that with the cost of electric power at 1.5 cents per kilowatt hour the cost of the current required to precipitate the silver from 100 gallons of exhausted hypo was approximately \$3. In comparison with the costs involved with the zinc and sulphide methods, this figure is prohibitive. Since electrolysis usually precipitates the silver as sulphide, it is obviously cheaper to use chemicals.

Within recent years two commercial electrolytic units have appeared on the market, one of which consists essentially of a number of zinc plates and a copper plate, bound together, but insulated from each other. The second type consists of a zinc plate and a bag of copper ribbon connected externally by a metallic wire. When the latter unit is placed in an exhausted hypo bath, silver is displaced by the zinc, and a silver-zinc cell is set up which causes the deposition of silver on the copper, and the zinc passes into solution. The current set up by the units is sufficiently low to ensure the deposition of silver and not silver sulphide.

Although it has been recommended that electrolytic units should be placed in the fixing bath while it is in use, whereby the fixing life of the bath is prolonged by virtue of continual removal of silver, this procedure is not of commercial importance. The hypo bath is somewhat revived by the removal of silver by the units, but it is not rejuvenated to such an extent that

its properties approach those of a fresh bath. The units cause bad sludge formation if they are placed in a working acid fixing bath unless the bath is well loaded with silver, and even in this case a certain quantity of sludge forms.

The value of electrolytic units lies in their use as silver recovery media, that is, for depositing silver from discarded fixing baths. When treating moderate quantities of solution, the units are efficient and require a minimum of labor since the operations of precipitation, filtration or decantation and drying of sludge are unnecessary.

Practical Recommendations

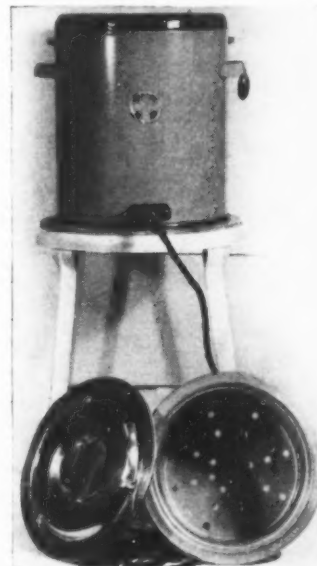
For silver recovery on a large scale precipitation with sodium sulphide is the most economical. Precipitation with zinc dust, although not so rapid, is efficient and has an added advantage in that no hydrogen sulphide fumes are evolved as in the sulphide process.

Although, in the hands of a capable chemist, it is possible so to restore a fixing bath by desilvering, subsequently clarifying and modifying its composition that its useful life is prolonged, it is just as economical and is preferable to prepare a fresh bath. In order to revive a bath after desilvering, it is necessary to add a quantity of hardener equal to that originally used and also a quantity of hypo equal to 50 per cent of the original quantity used. The resulting bath has approximately only three-fourths the life of a fresh bath.

Generally speaking, no saving whatever is effected by utilizing a desilvered and revived hardening fixing bath at the present low market cost of hypo in comparison with the value of the sensitive materials fixed therein. It is false economy to risk the destruction of valuable sensitive materials and the production of images of questionable permanency by using desilvered hypo.

electric connection made, and within ten minutes the stipes are ready for use. After the water and stipes have once been heated, only five minutes is required for subsequent hourly treatments.

Hot sterile dressings may also be given with this equipment. The steamer



is boiled until it is sterile, when it is ready to receive sterile dressings moistened with sterile water. A tray may be kept at the bedside to contain the sterile and nonsterile forceps for handling the sterile and soiled dressings.

This has been used most successfully by the University Hospitals of Cleveland.

Adjustable Bed Attracts Attention at Convention

A new and much more flexible bed interested a great many hospital superintendents and nursing supervisors at the last American Hospital Association convention in Philadelphia. It has all the advantages of a standard adjustable bed with improvements.

The center of the bed can be made rigid through the adjustment of two light metal fingers on each side of the center of the fabric.

The mattress is in four sections, with long head and foot sections which are nearly square, and two smaller center sections.

A small crank on one side of the bed raises up the inner edges of the head and foot sections of the mattress and releases the pressure on the two center sections. These two sections then move apart at the middle leaving an opening in the center of the bed where a tilting bedpan appears.

Aside from the convenience of an automatically available bedpan, the center crank makes it possible to adjust the mattress sections so as to redistribute the weight of the patient.

Electric Stipe Kettle for Hot Sterile Dressings

The procedure for preparing stipes or fomentations passed through several stages of development before a manufacturer of electrical equipment placed upon the market a deep casserole with hidden heating elements.

The lining of this casserole is baked enamel on steel. It does not easily chip from bumping or crack from being allowed to boil dry. The casserole is very deep and holds a large quantity of water, thus reducing the frequency with which it must be replenished. The heating elements are so arranged that within ten minutes after inserting the plug the stipes are ready for use.

There are two heats, high and low. The flannels are placed in an aluminum tray with holes in the bottom and a lip edge which overlaps the top of the casserole, supporting the steamer and

preventing the escape of steam. The lid covers the steamer to the edge and maintains a sterile area which makes possible the use of this kettle for hot sterile dressings.

In the center of the lid is a handle to which a wooden button may be attached which will protect the nurse from burned fingers. A manila tag bearing the patient's name can also be fastened to the handle. This entire equipment is placed on a 15-inch metal bath stool, insulated by a sheet of 3/16-inch pressed asbestos board, bringing the kettle to a convenient height.

When hot stipes are ordered, water is placed in the casserole and the stipes of flannel or terry cloth, moistened to speed the steaming process, are placed in the aluminum steamer. The whole is carried to the bedside, the

Fever Therapy Departments Seen as Coming Need in Hospitals

By Frank H. Krusen, M.D.

Director, Temple University Hospital, Philadelphia

THE marked interest recently manifested by physicians throughout the United States in the production of fever by physical means should attract the attention of hospital executives, for the time is coming when each up-to-date hospital will need a fever therapy department.

Over two hundred papers on artificial fever therapy have been published in the last year, according to a statement made in a recent issue of one of our lay magazines. Many of the larger hospitals now possess fever therapy departments, among them, Beth Israel Hospital, New York City; Boston Psychopathic Hospital, Boston; Cleveland Clinic Hospital, Cleveland; Duke Hospital, Durham, N. C.; Fifth Avenue Hospital, New York City; Harper Hospital, Detroit; Henry Ford Hospital, Detroit; Jefferson Medical College Hospital, Philadelphia; Jewish Hospital, Philadelphia; Mayo Clinic, Rochester, Minn.; Miami Valley Hospital, Dayton, Ohio; Milwaukee Hospital, Milwaukee; Milwaukee County General Hospital, Milwaukee; New York State Psychiatric Institute and Hospital, New York City; Starling-Loving Hospital, Columbus, Ohio; Philadelphia General Hospital, Philadelphia; the state hospitals of Illinois; Temple University Hospital, Philadelphia; United States Marine Hospital, New Orleans; Cincinnati General Hospital and Christian R. Holmes Hospital, Cincinnati; University Hospital, Ann Arbor, Mich.; University of Nebraska Hospital, Lincoln, and Strong Memorial Hospital, Rochester, N. Y.

Representatives from the fever therapy departments of these hospitals met recently in Dayton, Ohio, for the fifth annual Fever Therapy Conference, to present and discuss their observations and findings.

When to Use Fever Therapy

Among the diseases which they reported as possibly being amenable to fever therapy produced artificially by physical means, were gonorrheal urethritis, arthritis, and pelvic inflammatory disease; neurosyphilis; ocular syphilis; atrophic arthritis; chorea; pulmonary tuberculosis; multiple sclerosis; neuritis; bronchial asthma; Parkinson's syndrome; osteomyelitis, and peripheral vascular disease.

While opinions varied considerably as to the usefulness of artificial fever in all of these conditions, the results were so encouraging in many of them that it is certain this form of therapy

will gain wider recognition and use in the next few years. In gonorrhea alone, the results from all quarters were uniformly so good that one group of workers stated "it bid fair to supplant all other forms of therapy."

Artificial fever therapy (hyperpyrexia) should be strictly a hospital procedure. The council on physical therapy of the American Medical Association says: "The council believes that this method should be used only in hospitals, surrounded with the safeguards commonly employed in a major operation and under the direction of skilled physicians." The group at Dayton repeatedly stressed the necessity for having skilled nurse technicians to give these fever therapy treatments.

Various devices are used to produce the fever. Radiant heat cabinets, short wave diathermy machines and air conditioned cabinets head the list, but it has been noted repeatedly that it matters little what type of device is used, if it is adequate to do the work and if the technique of the physicians and nursing personnel is well organized.

Cost Is Warranted

These fever therapy departments are expensive to organize and to conduct; nevertheless, the income from the treatments can be adequate to support them. Many of the investigators feel that the possibilities of this particular form of therapy are sufficiently great to warrant almost any expense.

Dr. Franklin William Bock, Rochester, N. Y., reported on the basic principles for the cure of gonorrheal infection by a single fever treatment. This is accomplished by giving the patient the same length and height of fever as was required to kill, in vitro, the strain of gonococcus infecting that particular individual. Each case so treated was cured, according to the report. These fevers some of which lasted as long as twenty-two hours, were induced by radiant heat, the method being that developed by Dr. Stafford Warren, Rochester, N. Y. All cases of Neisserian infection do not require such heroic treatment. Some reports showed a cure in 90 to 100 per cent of the cases treated with one or more fevers of five hours' duration, at a rectal temperature level of 106 to 107 degrees F.

Reports such as these came from many of the hospitals mentioned. At the Beth Israel Hospital, New York City, pelvic inflammatory disease is be-

ing treated successfully with a combination of systemic fever (radiotherapy) and local diathermy. The report of Dr. A. U. Desjardins of the Mayo Clinic on the treatment of gonorrheal urethritis by fever therapy, was most convincing, and those made on the treatment of syphilis were encouraging. Some cases of chronic infectious arthritis (atrophic) are said to be benefited by fever therapy.

A longer period of study is necessary before accurate deductions can be made. Dr. Philip S. Hench, Mayo Clinic, reported on 147 such cases as follows: 10 per cent symptom free; 25 per cent marked improvement; 35 per cent moderate improvement; 30 per cent little or no improvement.

With interesting and promising results coming from so many important medical centers, it seems wise for hospital executives to investigate this method of treatment, to consult with institutions that are doing this work and to consider the careful organization of departments of their own.

Cost Study of Paper Versus Cloth Diapers

From time to time various hospitals have explored the possibilities of using disposable diapers. In any discussion of this subject the question of cost immediately arises. Cost is not, however, the only consideration. We must also consider the problem of hospital odors, sanitation, convenience, possibility of infection, and the patient's comfort.

In a recent study made at the University Hospitals of Cleveland the following facts were developed:

Paper Diapers

Cost of small size.....\$0.0102 ea.
Cost of large size..... .0127 ea.

Cloth Diapers

Cost of small size cloth....\$0.0004 ea.
*Laundry of small size..... .0015 ea.

Cost of use of small size....\$0.0019 ea.
Cost of large size cloth.... .0006 ea.
Laundry of large size..... .0023 ea.

Cost of use of large size....\$0.0029 ea.

SUMMARY

Small Size

Cost of paper diaper.....\$0.0102 ea.
Cost of cloth diaper..... .0019 ea.

Net saving by using small cloth diaper\$0.0083 ea.

Large Size

Cost of paper diaper.....\$0.0127 ea.
Cost of cloth diaper..... .0029 ea.

Net saving by using large cloth diaper\$0.0098 ea.

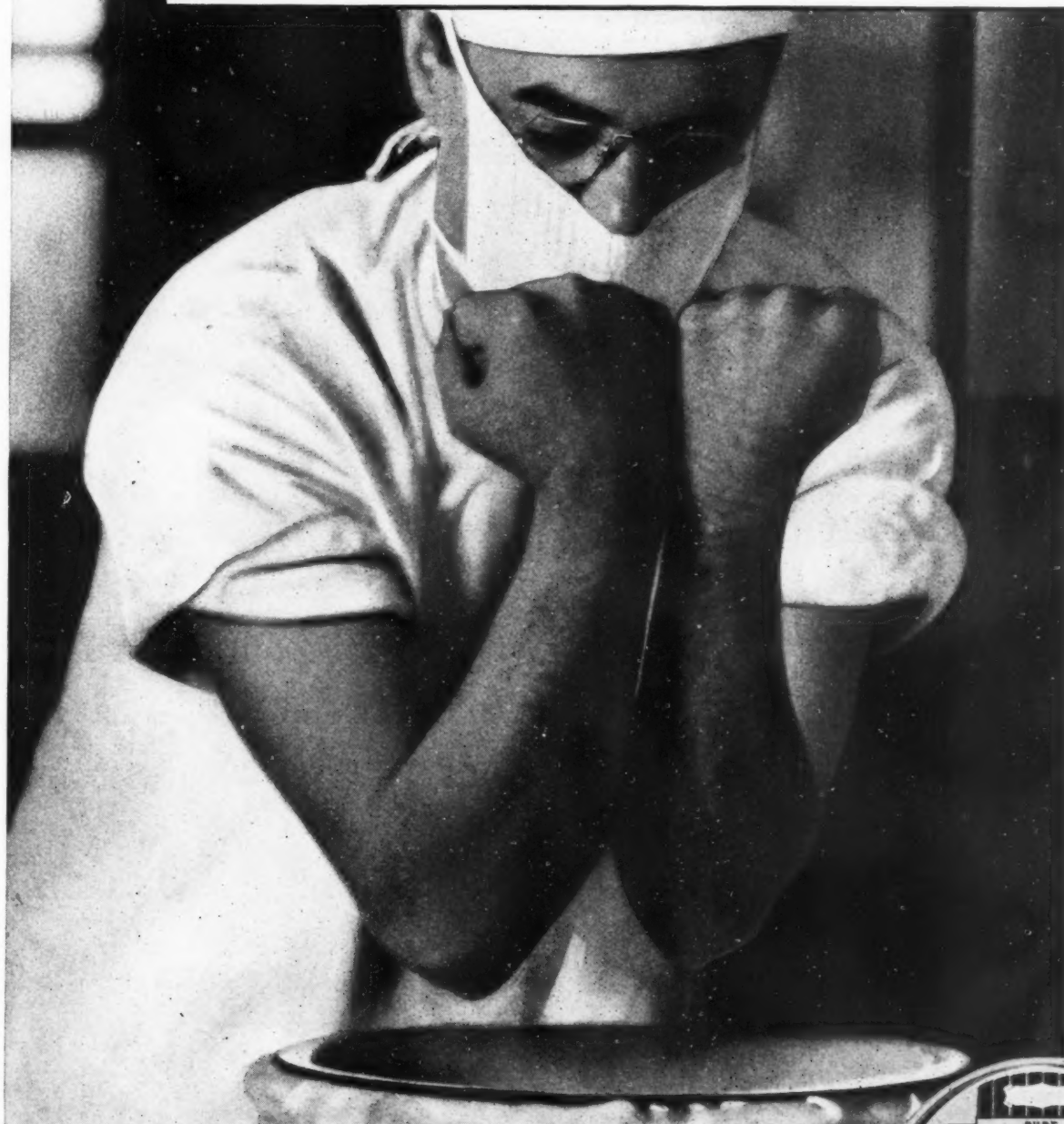
*The life of cloth diaper is figured at 156 washings (actual experience). The above calculations are based upon a laundry cost of \$0.0195 per pound.

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FOOD SERVICE

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Choosing the Dietary Personnel

By Irma Hug

Dietitian, Chicago Memorial Hospital, Chicago

THE personnel of a dietary department determines the efficiency and atmosphere of that department. It is true that management, equipment, kitchen traffic and general working conditions are of the utmost importance, but given these and a poorly chosen personnel, defeat of purpose results. The smaller the hospital, the more important it is to choose all personnel carefully.

Someone has defined personnel as the "collective characteristics of a group of persons employed." It does not take long for a keen observer to form an opinion of the personnel of a kitchen and of the manager of that personnel.

A spirit of determination, loyalty, cooperation and solidarity of purpose is the kind of atmosphere all dietitians aim to create. When the worker feels that his daily duties are more than just a job, and that he is an essential part of an organization, his efficiency and true good nature develop.

In spite of modern time saving and labor saving equipment, man power, hand power and human supervision are still needed. The real personnel manager realizes first and foremost that his workers react to situations more or less as he does himself. The time has come when people are being hired to do more than simply expend a certain

amount of energy to keep a position.

In hiring kitchen workers at this hospital an effort has been made to choose individuals whose appearance, attitude, temper and physical health contribute to the favorable atmosphere we are trying to create. A distinct effort has been made to combine good nature, efficiency, and the impetus to work well so that our employees may find genuine enjoyment in necessary routine.

Realizing that an institution like a small community is unmerciful in its criticism and that the work of each person in the kitchen is vitally concerned with the efficient running of that department, much thought has been given to selecting and developing the personnel of this department. Past experience is taken into consideration in hiring workers, but if the fundamentals of cooking, serving and cleaning are known, we find that it is better to train them to do our jobs as we want them done.

Physical Examination Precedes Hiring

Every employee is given a physical examination when he is hired, which includes a Wassermann, the test for stool ameba and a typhoid inoculation. We insist that the Wassermann and

stool ameba tests be negative. There is a frequent check on these points, and if time off duty is a criterion of health, we must feel our record is excellent. Last year, the pots and pans washer was off duty two days because of a cut finger. That was the extent of time off duty for sickness among the dietary personnel.

The dietary department of this 100-bed hospital is under the direction of one dietitian, and everything pertaining to this department is under her supervision. All food and equipment purchasing, hiring and firing of kitchen help, menu planning, therapeutic diets and the housekeeping of the dietary department come under her jurisdiction. About four hundred and fifty meals are served each day. There are ten workers in the kitchen. With the exception of the first cook, all our help are colored, and the age range, except for the second cook who is forty-five, is between thirty and thirty-five years.

Modified Central Service

Our system is a modified central service. The food is put on plates by the cooks and placed on racks in electrically heated carts. All food for special diets and special orders is prepared by the two cooks and placed on marked plates in the general food carts. Salads, dessert services, weighed diabetic diets, between meal nourishment, and special cold foods are prepared in the diet kitchen by the diet kitchen maids.

Graduate nurses, assigned to the duty kitchens on the floors, transfer the food from the hot and cold carts, on to the set-up patients' trays, using the diet slip as a guide. Each supervisor makes out a diet slip with the room number, diet and name of the patient. There is a space reserved for special diets and these are written by the dietitian for every meal.

Each morning the dietitian checks the diet slip with all floor supervisors and is informed of the condition and dietary need of each patient. Menus are written one week in advance, and all special diets are modified from the general menu. The diabetic tray is the only one that is weighed.

Personal Interest Shown

A small hospital serves its patients as efficiently and adequately as a large hospital. Every function, every routine duty, every order is carried out with the same regard and thought as in a larger hospital. The difference probably is that the smaller hospital serves its patients and doctors with a personal feeling and individual interest. It is a challenge to the ingenuity, versatility and creative ability of the worker to tackle a job that is many jobs in one. To do it well is the daily problem.

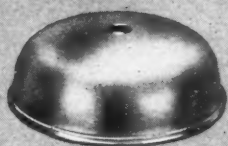
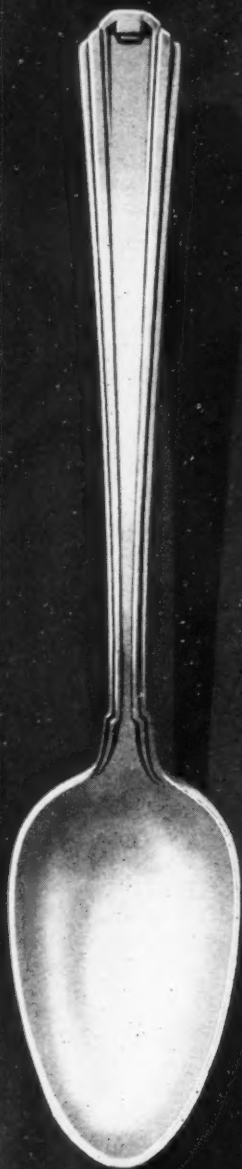
As a criterion of the adequacy of the hospital menu, some calculations have been made. The figures are given



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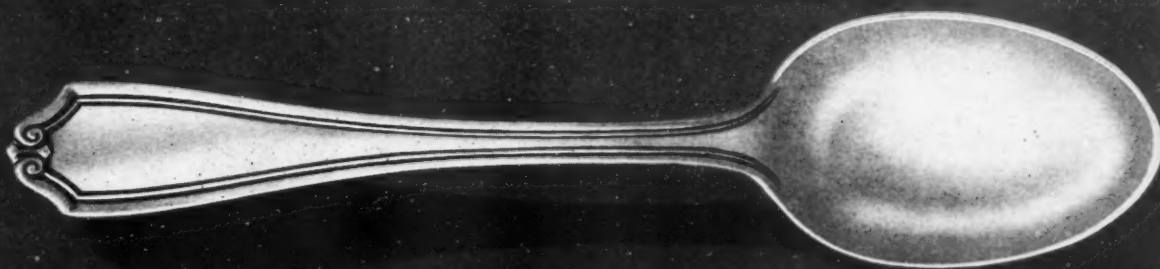
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merely as a basis of comparison and judgment. The consumption per capita per day of the various foods is approximately the same each month. These figures were taken from food consumed per capita during the month of February, 1935.

Approximate amount consumed per capita per day:

Milk96 pint
Cream	2.1 ounces
Butter	1.34 ounces
Eggs	1.13 whole
Meat51 pound
Sugar51 ounce
Potatoes57 pound
Bread	3.3 ounces
Citrous fruit 1.06 (whole) including orange, grapefruit or lemon	

The percentage spent for the various food groups is as follows:

Milk, cream, ice cream.....	20.1 per cent
Fruit, vegetable, potato.....	26.0 per cent
Meat, fish, egg.....	29.0 per cent
Butter, fat, sugar, flour, groceries	15.6 per cent
Bread, cereal	9.3 per cent

Small Hospital Dietitian Counsels the Community

By Ruth Nancy Nickum

Dietitian, Victory Memorial Hospital, Waukegan, Ill.

A WELL conducted hospital dietary department can do much for patients by substituting sound advice on food problems for the pseudo-scientific commercial propaganda that invariably produces faulty diet habits. It has been said that there are two types of persons, those who eat to live and those who live to eat, and that both are equally in need of scientific advice regarding food selection. It is the duty of those interesting themselves in food composition to combine these two groups into one having the best features of each.

The attitude towards dietary requirements during the past few years

has changed radically. Cases calling for nephritic diets, which make up a considerable portion of the dietitian's weighing, measuring and combining, seldom show the pronounced anemia that was formerly so much a feature of this condition. The few typhoid cases still seen can, with the modern knowledge of diet, go through this illness without weight loss, and may even gain, in contrast to the loss of twenty or thirty pounds accompanied by other features of dietary deficiency that were accepted as part of this disease in the past.

Several years ago the physician was apt to order a low starch and carbohydrate diet to reduce the distension so hard to combat in decompensation. Scientific work proved that an abundance of glycogen was the essential factor for sustaining the heart muscle, and now diets are ordered with that in mind.

Success in the treatment of pernicious anemia and more recently in the treatment of pellagra, in the South, shows still further the importance of dietetics. In writing on diet and modern living, one must take into consideration the fact that many people during the past four years have had less opportunity for a varied choice of food-stuffs and consequently are more apt to leave out those containing necessary vitamins.

Importance of Vitamin Balance

The recently published work of an English physician shows the tremendous importance of vitamin balance for proper hardness of teeth. A dietitian must continually keep in mind that on diets calling for restriction over long periods of time, as in ulcer, obesity or diabetes, the factor of vitamin content is of high importance. The financial stringency of recent years is bound to result in some dietary deficiencies, but not as much as was first expected because of the close attention to balanced rations arranged by FERA dietitians.

A troublesome feature complicating the dietitian's work is the enormous publicity campaign being conducted by manufacturers of foodstuffs. The doctor may carefully prescribe and the dietitian prepare a program suited to an individual patient who will later supplement it by following advice read or heard on the radio, the net result being that the patient, the doctor, the dietitian, and the food manufacturer all fail to come up to expectations.

People are more food conscious than ever before, but they tend to follow

No. 13 — Serpentine Salad

By Arnold Shircliffe*



Lettuce
Cucumber

Pimiento

ON A bed of lettuce, place serpentine strings of cucumber. To enhance the color, add a few strips of highly colored pimiento. To curl cucumber, peel a young hot house cucumber, cut off ends, and cut into two-inch pieces. Then cut cucumber into thin continuous strip, cutting around and around the long side until center is reached. Curl the large serpentine strip back into shape and cut across to make thin strings. Serve with a thick sour cream dressing.

*Author of the Edgewater Beach Salad Book.

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ALLERGIC TO WHEAT,
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milk, eggs or a combination of all three.

To assist you, or your patients, in planning interestingly varied menus, a booklet has been prepared by a reputable dietitian with the cooperation of physicians interested in allergy. Separate sections are allotted to wheat, milk and eggs. In each, allowed and forbidden foods, sample menus and recipes are given. We'll gladly send you a copy of this booklet, with samples of Ry-Krisp for testing. Additional copies for distribution among your patients are available upon request. Simply use the coupon.



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fads. It is said that the Mayos deny using what was referred to as their famous eighteen-day diet, except on a few selected cases. A famous French novelist referred to the gastro-intestinal tract as the seat of the emotions, having in mind that all moods and emotions as well as most pathologic conditions stir up disagreeable or agreeable responses in the abdomen.

It is easy for one so disposed to go on a diet of his own devising. Persons vary in the extremes to which they carry out these programs, but practically all of them are unsatisfactory diets.

I recall a case a physician described to me of a wealthy woman who for five years had eaten nothing but potatoes, rice, carrots and an occasional baked apple and milk. This was at one time her doctor's order, but instead of the week's use he prescribed, she prolonged it unreasonably and to the point where

psychosis and heart failure began. The case cleared up completely under a forced diet of foods of known vitamin content.

A case of beri-beri in a millionaire is something to think about, and, although a rarity, it shows the need there is for sensible instruction in food habits.

A discussion of diet and modern living has so many ramifications that it is little wonder the public is at the mercy of clever advertisers. The not uncommon attitude that "talk of vitamins is the bunk, for people lived to a ripe old age before they were discovered," seems to be a rebellion against the constant pseudo-scientific ads and articles the layman is compelled to read. The danger lies in the possibility that the dietetic program, which has come about through this isolation of vitamins, will lose value because of the domination being gained by the faddist.

seems necessary, to teach them a few points about ethics and good manners.

The head should always be alert, wide-awake and well read. Should the help ask you something which you do not know you should answer, "I am not quite sure about it, but I will be more than glad to look it up for you." It is not always what you know that is important but rather how quickly you are able to find the information. Keep up on all the current news of the day and the most recent things in science. The psychologic worth of apparently knowing the answer to everything is often found valuable.

Hospital Cuts Food Waste

A new system was inaugurated recently in the dietary department of Hackensack Hospital, Hackensack, N. J., the chief feature being a selective menu for private patients. Each private patient is visited daily by the dietitian and allowed to select the food desired. So far the results have been pleasing by making it possible to give a larger and more attractive variety, the hospital reports. There is no increase in cost and less waste since all orders are placed in advance. If a patient does not care for bread it is not ordered, hence does not meet its destiny in the refuse can.

With the installation of the new system it was necessary to have additional equipment for transporting the food from the main kitchen to the serving pantries on the floors. Two food trucks were purchased for this purpose one to carry the hot foods to the dumb-waiters and one to carry the cold foods to the floors.

When Is a Banana Ripe?

The banana is unquestionably a valuable addition to the diet. The chief point in regard to it which is stressed by gastro-intestinal and pediatric specialists and by dietitians is that bananas must be ripe.

Unfortunately few people know the difference between a ripe banana and a decaying banana; yet they readily enough recognize a decaying apple. The same method of discrimination applies to both fruits: a bruised apple with a broken skin immediately begins to decay, due to the invasion of bacteria; in a bruised banana or one with a broken skin the same thing happens.

Therefore, bananas should not be torn from the bunch, but should be cut off, just as apples should be hand picked, not windfalls. The cut should not be through the fruit, but through its stem. The banana may then be laid in either a cool or a warm place until it becomes a pale brown color. It will then be found ripe, not decayed, and will be wholesome and digestible.

Using Psychology in Dealing With Help

By Frances Staples

Formerly Dietitian, Central Texas Baptist Sanitarium, Waco, Tex.

PSYCHOLOGY plays an important part in handling help. It has been my experience that suggestions rather than commands should be used in order to get the most efficient work from employees. Kindness and cheerfulness are assets in the head of any department, and especially so when that department is one connected with the feeding of the sick. A smile does not cost a cent but grouching is apt to prove expensive in the end.

One way of managing colored help is to give them extra time off. They work more willingly when some favor has been granted them. Our hospital is small and in the summer, our busiest season, we average fifty patients daily. We cannot afford to give paid vacations, so in order to have any time off we double up.

Developing a Friendly Atmosphere

The department head has to adapt herself to the environment of her workers in order to understand them. It is not necessary to allow familiarity from them, but friendliness and congeniality have an important place in the relationship of head and helper.

Something nice and complimentary said regarding their work spurs these employees on to greater desires and ambitions. Too much severity in criticism does more harm than good.

Consideration of the health and happiness of her employees is necessary on the part of a department head. She must not overwork them or they will be tired and grouchy and apt to slight their work in order to get through.

She must have regular working hours for herself and her employees. The department head is entitled to privileges, but if she absents herself too often part of the work will be left undone. Kitchen workers have been known to change the menus to suit their own likings.

Honesty is another important factor in dealing with your help. Never make the habit of promising them something and then neglecting to keep your promise. If you do this, they will soon lose all faith in you. If your employees believe that you are the grandest person on earth they will not leave you. They must have confidence in you, and you in them. You should have enough confidence in your employees to trust them. There are numerous occasions when the department head is called away, and her work should be so arranged that she may leave without any worries, knowing that the work is being carried on in her absence. This feeling is an asset to any department.

Winning Respect

Teach your workers that if they want anything the best and easiest way of getting it is by asking for it. It is unfair to yourself and your employees to permit the "Oh I'll just take it, she won't miss it," attitude to develop.

Teach your help to respect you and all members of the staff. They must not be allowed to get the idea that they can run your business and your affairs. They should always say, "Good morning," "I beg your pardon," and "Thank you." Go a little out of the way, if it

Take your choice



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Decreasing Food Waste

By Elizabeth Cole, M.A.

Department of Nutrition, Montefiore Hospital, New York City

A STUDY of food waste has been conducted more or less continuously at Montefiore Hospital for Chronic Diseases, New York City, since 1930. By separating the edible and inedible portions, the edible food waste, excluding liquids, has decreased as follows:

Year	Patients	Staff and Employees
1930 (4 months)	12.0 oz.	
1931	10.0 oz.	
1932	9.0 oz.	6.5 oz.
1933	5.5 oz.	5.0 oz.
1934	3.5 oz.	3.0 oz.

This saving has been made possible through the cooperation of the nursing department and the direct attention given to the problem by the administration. Every effort has been made to encourage patients to ask for second helpings if additional food is desired, but they are also reminded that food must not be wasted. The quantity of food per capita per day and the percentage of total food cost have been calculated each year, and the results show that a well balanced menu is provided each patient in the proper quantities.

The actual savings effected through this reduction in food waste amount to

approximately 64,000 pounds for the year 1933, and 134,000 pounds for 1934. This is exclusive of the savings on fresh fruit and vegetables and also on the miscellaneous item — groceries. Because the majority of these are not purchased by weight, no account has been taken of them in any of the comparisons. The accompanying table shows a comparison of the quantities of food used in 1933 and 1934 as compared with those of 1932.

The total food costs for 1934 increased slightly but only in proportion to the increase in the number fed. Notwithstanding an increase of 32 per cent in wholesale food costs as recorded by the U. S. bureau of labor statistics for the years 1933 and 1934, the per capita cost is not increased — a fact to be attributed to the attention given to the prevention of food waste.

The only additional expense involved in studying food waste is the cost of labor for one half-time employee who weighs the food waste as it comes from the wards, dining rooms and kitchens. This represents a saving on the principal items of food as listed here, estimated on average prices, for the two years of \$8,700. This is more than twenty times the cost involved in the weighing of the food waste.

Food Quantities Used in 1934, per Capita per Day

Meat, fish and poultry	8.4 oz.
Milk	.7 qts.
Cream	1.4 oz.
Butter	1.3 oz.
Eggs	1.7 eggs
Cheese	.5 oz.
Potatoes	9.1 oz.
Flour	4.5 oz.
Coffee	.6 oz.
Sugar	2.5 oz.

Food Costs in 1934, per cent Total Food Cost

Meat, fish and poultry	23 per cent
Milk and cream	17 per cent
Butter	6 per cent
Eggs and cheese	12 per cent
Fresh fruits and vegetables	14 per cent
Canned fruits and vegetables	10 per cent
Groceries, staples and miscellaneous	18 per cent

COMPARISON OF FOOD QUANTITIES USED WITH THOSE OF 1932

	1933		1934	
	Decrease	Increase	Decrease	Increase
Flesh foods	10,108 lbs.		2,258 lbs.	
Milk and buttermilk	4,428 qts.*		17,325 qts.*	
Cream	1,122 qts.*		2,802 qts.*	
Butter	4,189 lbs.		5,104 lbs.	
Eggs		1,716 lbs.		5,729 lbs.
Cheese		795 lbs.		940 lbs.
Potatoes	23,130 lbs.		65,695 lbs.	
Flour	13,661 lbs.		20,943 lbs.	
Coffee	2,408 lbs.		2,725 lbs.	
Sugar	2,341 lbs.		3,067 lbs.	
	66,937 lbs.	2,511 lbs.	140,046 lbs.	6,669 lbs.

*Counting 2 pounds to the quart.

FOOD FOR THOUGHT

• An interesting piece of research on ovenware and fuel economy was reported recently in the *Journal of Home Economics*. The conclusions reached were that the type of utensil, both size and shape, has a great deal to do with the temperatures required. A comparison of the amount of fuel saved is given for the various types of utensils. It would be worth while looking up this article, if you have not seen it.

• The hospital program of the Tri-State Hospital and Dietetic Associations had a particularly interesting set-up. Hospital problems were presented from the viewpoint of each hospital worker. Dietitians were represented on practically every program.

Ada B. Lothe, Milwaukee County Hospital, Wauwatosa, Wis., stressed the importance of the nurse as a teacher of health, and the necessity of giving her an educational background upon which she can evaluate food consumption and interpret food requirements to the patient. The trends in education were discussed by Mary M. Harrington, Harper Hospital, Detroit, while Katherine Mitchell, Michael Reese Hospital, Chicago, presented the administrative angle.

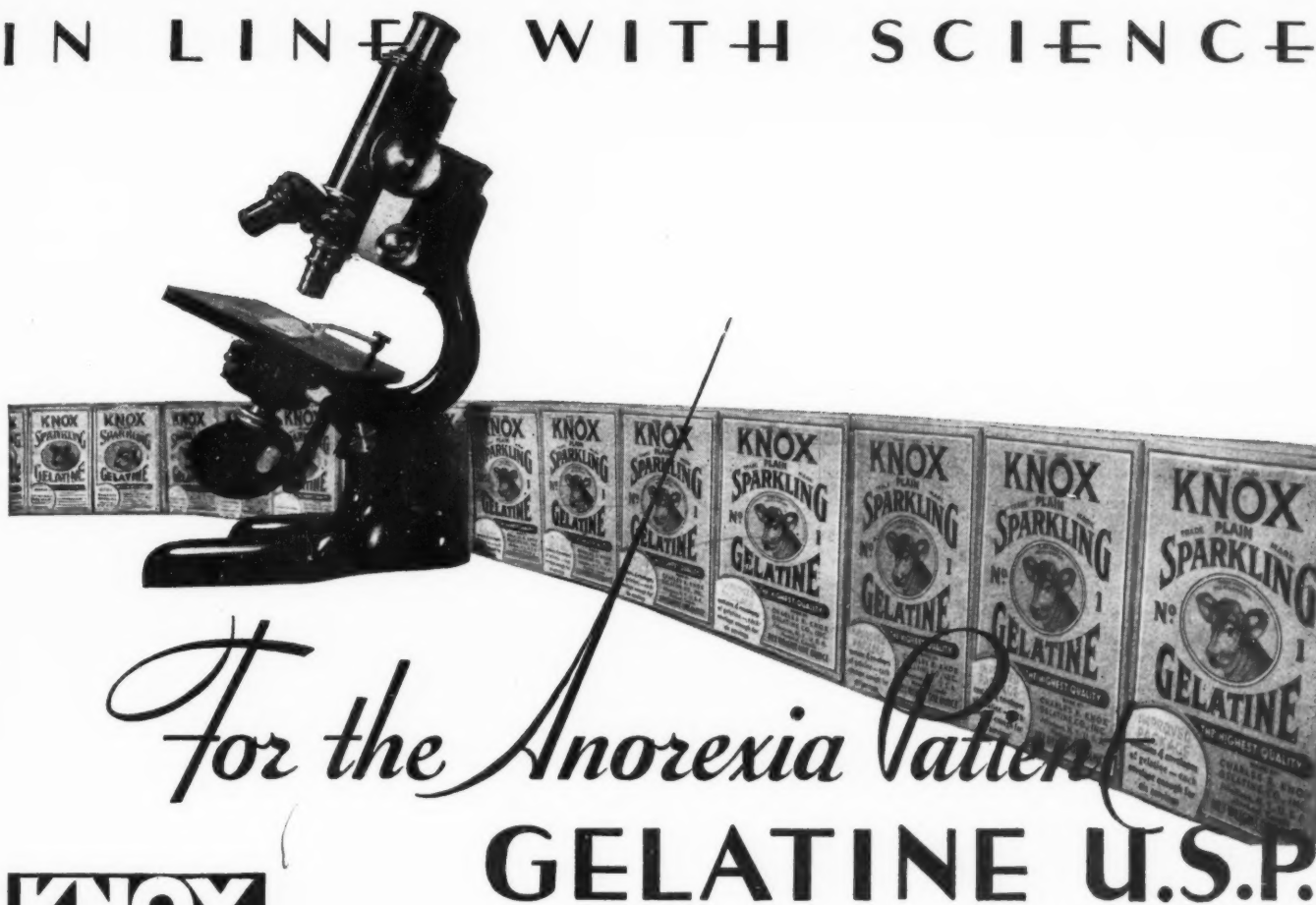
Ruth Atwater, National Canners Association, Washington, D. C., told of the new labeling that is being urged by the government, and explained why it will be a great disadvantage to the person doing the purchasing. Vera McGowan, Evanston, Ill., outlined the factors that are important in controlling food department costs. Brena Dietz, Harding's Restaurants, Chicago, talked on managing employees.

Two outstanding scientific papers were presented. E. B. Hart, University of Wisconsin, reported work on the availability of organic iron as compared with that of inorganic iron. Dr. Floyd H. Lashmet, University of Michigan, presented further data on the acid ash diet, which is being used successfully in cases of edema.

• Some interesting work has been carried on at Columbia University on the prevention of discoloration of sliced bananas. Many dietitians have already received this information, but those who have not will probably be glad to know that by slicing bananas into a solution of cream of tartar, water and corn syrup, they will remain firm and light in color for as long as two hours after removal from the solution. If you have not received these formulas, by all means write in for them.

• A diet manual which is only a few months old has recently been received from Mount Sinai Hospital, Philadelphia. It is a nicely prepared set of diets, and may be borrowed from the library of the American Dietetic Association. Our copy is available, too.

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Fat (less than)	0.1%
Moisture	13.0-14.0%
Carbohydrate	Nil

Of interest in the treatment of muscular dystrophy is the 25% glycine in Knox Gelatine.

Knox Gelatine contains no carbohydrates; bacteriologically safe, and a pH of about 6.0. The total metal content is less than half that allowed by U.S.P.



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Knox Sparkling Gelatine is the gelatine of professional choice. Its colorful, tempting recipes are numerous and varied. Appealing to eye and stomach of patient, Knox Gelatine provides easily digested, important amino acids for utilization in tissue building and for energy. Adults enjoy it as greatly as children.

Knox Gelatine is exceptionally pure. By specifying Knox you can be certain of better than U.S.P. (It contains no coloring matter or flavoring as in factory-made jells.)

Quite a remarkable product—made as carefully as an ampule solution. For the diabetic, convalescent, tubercular, high-protein, post-operative and infant diet where higher protein content is desirable.

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August Breakfast and Supper Menus

By HELEN E. GILSON and STAFF
Dietary Department, Pennsylvania Hospital, Philadelphia

BREAKFAST			SUPPER				
Day	Fruit	Main Dish	Appetizer or Soup	Meat, Fish or Substitute	Salad or Vegetable	Bread and Relish	Dessert
1.	Fresh Pears	German Coffee Cake, Cherry Conserve	Alphabet Soup	Manhattan Roll, Vegetable Sauce	Cabbage, Raisin and Apple Salad		Vanilla Ice Cream, Sand Tarts
2.	Fresh Plums	French Toast, Maple Syrup	Tomato Broth	Cold Cuts	Potato Salad	Rye Bread, India Relish	Watermelon
3.	Royal Anne Cherries	Banana Muffins, Grape Jelly	Fruit Punch	Mixed Grill	Asparagus Salad		Gingerbread
4.	Stewed Apricots	Soft Cooked Eggs	Duchess Soup	Southern Chicken Shortcake	Lettuce Hearts		Raspberry Junket
5.	Nectarines	Creamed Beef	Consommé	Assorted Sandwiches	Pear Salad	Sweet Pickles	Fudge Squares
6.	Fresh Plums	Parker House Rolls, Strawberry Jam	Jellied Chicken Broth	Cornbeef Hash	Waldorf Salad		Cinnamon Buns
7.	Cantaloupe	Broiled Bacon	Orange Ice	Creamed Hamburg on Toast	Tomato Salad	Pimiento Relish	Sour Cream Cake
8.	Bananas	Scrambled Eggs	French Onion Soup	Baked Noodles and Chipped Beef	Sunset Salad		Cream Puffs
9.	Oranges	Poached Eggs	Appledore Soup	Sweetbread Salad		Bran Muffins	Raspberry Ice, Butterthins
10.	Fresh Plums	Bacon Muffins, Applebutter	Cream of Chicken Soup	Sardine Salad	Tomato Slices	Raised Rolls	Watermelon
11.	Fresh Peaches	Broiled Ham	Bouillon	Toasted Cheese Sandwich	Fruit Salad		Coconut Layer Cake
12.	Bananas	Fried Eggs	Cantaloupe	Chicken Salad	Baking Powder Biscuits	Sweet Pickles	Tapioca Meringue
13.	Cantaloupe	French Toast, Maple Syrup	Jellied Consommé	Hot Roast Beef Sandwich	Pickled String Beans	Dill Pickles	Grapes
14.	Grapefruit	Oatmeal Muffins, Cherry Conserve	Scotch Broth	Cold Cuts	Potato Salad	Mixed Pickles	Fruit Cup, Boston Cookies
15.	Stewed Prunes	Broiled Bacon	Vegetable Soup	Deviled Egg Salad	Potato Chips		Toasted Coconut Ice Cream, Pretzels
16.	Fresh Pears	Poppy Seed Rolls, Orange Marmalade	Fruit Punch	Chow Mein	Tomato Salad		Cup Cakes
17.	Winesap Apples	Scrambled Eggs	Julienne Soup	Tuna Fish Salad	Shredded Wheat Rolls		Vanilla Junket
18.	Cantaloupe	Soft Cooked Eggs	Scotch Broth	Macaroni and Cheese	Sliced Cucumbers and Radishes		Assorted Fruit
19.	Royal Anne Cherries	Twin Mt. Muffins, Strawberry Conserve	Raspberry Ice	Assorted Sandwiches	Waldorf Salad		Chocolate Blanc-mange
20.	Fresh Pears	Broiled Ham	Beef Broth	Stuffed Creamed Egg on Toast	Tomato Slices		White Nut Cake
21.	Stewed Figs	Fried Eggs	Fruit Cup	Broiled Ham	German Potato Salad	Mustard	Coffee Gelatin, Whipped Cream
22.	Watermelon	Fried Mush, Maple Syrup	Mulligatawny Soup	Jellied Beef	Shredded Lettuce, Bacon Dressing	Bran Muffins	Fresh Peach Ice Cream
23.	Bananas	Cinnamon Biscuits, Apple Jelly	Consommé	Chicken à la King	Perfection Salad		Baked Pears
24.	Plums	Scrambled Eggs	Noodle Soup	Rice Boubons	Cucumber Salad, Beaten French Dressing		Apple Dumplings
25.	Grapes	Date Muffins, Orange Marmalade	Fruit Punch	Hamburg Sandwiches	Celery		Baked Custard
26.	Fresh Peaches	Creamed Beef	Beef Broth	Tuna Fish Salad	Sweet Dill Slices	Raisin Bread	Fresh Pineapple, Oatmeal Cookies
27.	Fresh Pears	Soft Cooked Eggs	Lemon Sherbet	Dried Beef à la King on Griddle Cakes	Pickled Beets		Filled Cookies
28.	Applesauce	Omelet	Iced Cantaloupe	Escalloped Ham and Potatoes	Lettuce Hearts		Prune Whip, Butterthins
29.	Bananas	Bran Muffins, Applebutter	Vegetable Soup	Baked Beans	Coleslaw	Brown Bread	Raspberry Ice Cream, Pretzels
30.	Plums	Broiled Bacon	Pineapple Juice	Creamed Sweet-breads on Toast	Tomato Salad		Cinnamon Apples
31.	Stewed Apricots	Shredded Wheat Rolls, Orange Marmalade	Consommé, Asparagus Tips	Egg Croquettes, Creamed Peas	Shredded Lettuce, French Dressing	Rye Bread	Iced Cantaloupe

*Cereals and beverages are omitted from the breakfast menus because of space limitations. Recipes for any of the foregoing dishes will be supplied on request by Anna E. Boller, Central Free Dispensary, Rush Medical College, Chicago.



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AMERICA'S LEADING **TEST** **COFFEE**

Vol. 45, No. 1, July, 1935

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(M.H.-7-35)

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NEWS IN REVIEW

International Hospital Association Moves Headquarters to England; Changes Policies

The International Hospital Association has moved its headquarters from Switzerland to England, transferred all its bank accounts to Martin's Bank, Liverpool, and changed its medium of exchange from the Swiss franc to the English pound sterling in accordance with decisions reached at the congress held in Rome, Italy, May 19 to 25.

Further changes in the policies of the organization are evidenced by the fact that minimum subscriptions from government departments and national associations will no longer be requested, and consequently the policy of asking national associations to subscribe 5 per cent of their incomes has been dropped.

Firms and organizations are to be invited to become associate members at an annual subscription of two pounds English sterling, and individual associate memberships will carry an annual fee of one pound.

Over 1,000 delegates, representing forty-five different countries, attended the congress. Papers and discussions were given in the tongue of the speakers and then translated into English, Italian, French and German. The Accademia dei Lincei, where the meetings were held was admirably suited for such a gathering.

The local committee, assisted by the Italian government, had made arrangements to care for the congress and to give the delegates an opportunity to see something of old Rome and also something of the new Rome of Mussolini.

Trend Is Toward Standardization

Particular attention was given throughout the sessions to the fields of architecture, purchasing and accounting, personnel, management and equipment. The general continental trend seemed to be toward standardization without prejudice to the individualization demanded by local conditions.

The need for uniform methods of reports and statistics in order that results might be comparatively studied to the advantage of the entire hospital field was repeatedly emphasized, particularly by the committee on accounting headed by Captain J. E. Stone, secretary, Birmingham Hospital Center, Birmingham, England.

The congress decided to appoint a special committee including representatives of every country to review the entire constitution of the association and to submit new constitutions

and standing orders for the approval of the 1937 congress.

Dr. René Sand's plea was responsible for the decision to take the next meeting to Paris, and it is expected that unless the United States urges a prior claim, the 1939 meeting will be held in London.

Dr. G. von Deschwanden, Switzerland, was reelected president. Dr. Malcolm T. MacEachern, associate director, American College of Surgeons, Chicago, was elected vice president, as was M. Sarraz-Bournet, France. Sidney Lamb, England, was made general secretary and treasurer, and Dr. William Alter, Germany, Dr. E. H. L. Corwin, New York City, and Dr. René Sand, Paris, were elected honorary presidents.

The entire debt of the association, according to Mr. Lamb, has been canceled through funds collected by subscription and donation. Fourteen countries have already paid their subscriptions for 1935 or have promised a definite amount to be paid before the end of the year.

The Rev. Alphonse M. Schwitalla, official delegate of the American Hospital Association, the Catholic Hospital Association, and representative of the Protestant Hospital Association, Edward F. Stevens, Boston, who presented a paper in the section on architecture, Dr. Thomas J. Heldt, Henry Ford Hospital, Detroit, Dr. Donald M. Robertson, Ottawa Civic Hospital, Ottawa, Ont., and Dr. Arthur S. Moore, Middletown, N. Y., were the Americans present at the congress.—ARTHUR S. MOORE, M.D., Superintendent, Elizabeth A. Horton Memorial Hospital, Middletown, N. Y.

Administration Students at U. of C.

Three of the six students who have been pursuing the graduate course in hospital administration opened last autumn in the school of business at the University of Chicago have at the end of the spring quarter been offered and accepted excellent positions. Dr. Arthur C. Bowles has just started as assistant superintendent of Grasslands Hospital, Valhalla, N. Y., under Dr. C. W. Munger. Gertrude Kroeger, R.N., will do research work with the Julius Rosenwald Fund. Nellie Gorgas, A.B., will be assistant to Dr. Arthur C. Bachmeyer in the University Clinics of the University of Chicago.

Children's Bureau to Follow A. H. A. Recommendations

Arrangements have been made for the local supervisors for registration of social statistics in forty-eight states to make out reports at the Children's Bureau according to the standard definitions appearing in the uniform manual "Hospital Accounting and Statistics," published by the A. H. A.

Dr. C. Rufus Rorem who has been chairman of the advisory committee on accounting for the A. H. A. has also been special adviser on hospital and clinic statistics for the Children's Bureau. Arrangements have been made through Dr. Emma Winslow, registrar of social statistics, to use the A. H. A.'s report as the official instructions for the field workers.

This arrangement with the Children's Bureau will, it is hoped, be followed by agreements with other organizations accumulating hospital statistics to use standard definitions.

Paralysis Victims in Los Angeles

Thirty-two positive cases of infantile paralysis were reported at the Los Angeles County General Hospital, Los Angeles, as an epidemic attacked nurses and patients. In addition there are sixteen suspected cases and fifty-five under observation. Rex Thompson, county superintendent of charities, appealed to unemployed nurses for aid at the short-handed institution. The hospital is quarantined against visits from all but the immediate relatives of seriously ill patients and the drastic steps taken to isolate the disease within the boundaries of the hospital are reported to have been effective. All of the cases are declared mild.

Connecticut Housekeepers Meet

Twenty-one members of the Connecticut chapter of the National Executive Housekeepers Association held their first meeting at the New Haven Hospital, New Haven, Conn., in June. Among those present were Mrs. Grace Brigham of the Hotel Biltmore, New York City, national president, also Mrs. Jessie Addington, Presbyterian Hospital, New York City, second vice president and Mrs. Pauline Wood, newly elected president of the New York chapter. Officers of the Connecticut organization are as follows: president, Mrs. Gladys Hancock, Hartford Municipal Hospital; first vice president, Mrs. Gertrude Page, New Britain Hospital; second vice president, Evelyn Coolidge, New Haven Hospital; treasurer, Mrs. Catherine Mason, Norwalk General Hospital, Norwalk; recording secretary, Blanche Newton, Grace Hospital, New Haven, and corresponding secretary, Mrs. Lucy Myers, Middlesex Hospital, Middletown.

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Hospital Holds 75th Anniversary Celebration

The celebration of the seventy-fifth anniversary of the founding of the New York Homeopathic Medical College and Flower Hospital combined the commencement exercises of the college, the alumni association activities and the convention of the American Institute of Homeopathy during the week of June 2 to 7.

One of the outstanding features of the celebration was a pageant, presented under the direction of Frank Cambria. The cast included many members of the faculty, medical students and nurses, who depicted the history of medicine from the time of Hippocrates down to the present day, with especial emphasis on the last seventy-five years and the part played in them by the hospital.

The speakers at the official celebration of the anniversary were Charles D. Halsey, president of the board of trustees of the college; Dr. S. S. Goldwater, commissioner of hospitals, New York City; Dr. John L. Rice, commissioner of public health, New York City; Dean John Wyckoff of the New York University school of medicine; Dean W. A. Pearson of the Hahnemann Medical College of Philadelphia; Dr. J. T. Simonson, president of the American Institute of Homeopathy, and Dr. William Francis Honan, professor of surgery at Flower Hospital.

A unique publicity campaign conducted in connection with the formal celebration of the anniversary, was inaugurated by the appearance on the streets of New York of a white horse hitched up to an old horse-drawn ambulance, a reproduction of one used by Flower Hospital in 1893. An old-fashioned lantern hung by the driver's seat, and patients were required to lie on none too soft cushions on the floor.

Plans Crystallize for Hospital Institute in September

Plans for the 1935 Institute for Hospital Administrators, announced in previous numbers of *The Modern Hospital*, are advancing satisfactorily. The institute will be held as in former years under the auspices of the American Hospital Association, on the campus of the University of Chicago, September 11 to 25.

A group of well known hospital administrators from many parts of the United States will be among the lecturers and leaders of seminars, in addition to several of the Chicago group. Among the faculty members who are expected are Dr. B. W. Black, Oakland, Calif.; Mrs. Mary Hicks Bachmeyer, Chicago; Dr. R. G. Leland, Chicago; Dr. B. C. MacLean, Rochester, N. Y.; Dr. Christopher G. Parnall, Rochester, N. Y.; Dr. C. Rufus Rorem, Chicago;

Dr. Donald C. Smelzer, Philadelphia; H. J. Southmayd, New York City; Dr. Charles F. Wilinsky, Boston.

Dr. Malcolm T. MacEachern will conduct the evening round tables. The Chicago Hospital Association, under the presidency of Dr. Herman Smith, Michael Reese Hospital, Chicago, will cooperate in arranging for afternoon visits and demonstrations in local institutions.

Inquiries and applications should be addressed to Dr. Bert W. Caldwell, executive secretary, American Hospital Association, 18 East Division Street, Chicago.

New Zealand and Health Insurance

Approval of a system of national health insurance was recently voted by the Hospital Boards' Association of New Zealand, after careful study and the formulation of a plan of insurance by the executives of the association. The New Zealand Branch of the British Medical Association expressed its hearty congratulations to the hospital association and assured all bodies working in the interests of the community of its whole-hearted support and wish to cooperate in every way by investigating the possibilities of improvement to the present system.

The report of the Hospital Boards' Association was forwarded to the New Zealand government with a resolution urging that "legislation be introduced to give effect to same."

Elizabeth, N. J., Group Plan Extended to Include Unemployed Persons and Entire Families

Declaring itself to be the only group hospitalization plan which guarantees its members the payment of their hospital bills in any legally incorporated, nonprofit hospital in the United States or Canada, the Elizabeth General Hospital and Dispensary, Elizabeth, N. J., recently announced the expansion of its service to include hospitalization of unemployed as well as employed persons and all members of a family, regardless of how many, at a cost of from two to three cents a day a person.

For the last three years Elizabeth has had a plan covering employed persons, but under the expanded program coverage is offered anyone under sixty-five years of age in good health. The extension of the plan is based upon the study made in Newark, N. J., by Frank Van Dyk, present executive director of the Associated Hospital Service of New York.

The plan now provides that both parents and all dependent children under nineteen years of age in any family, may be assured three weeks' hospitalization for a maximum payment of two dollars monthly. This rate dis-

Ten-Year Report for Trustees

A report presenting statistical data covering a period of ten years, with special emphasis on the last four years, has just been published by Ralph M. Hueston, superintendent, Silver Cross Hospital, Joliet, Ill., for the benefit of the trustees of that institution.

A vividly presented report, it uses graphs to obtain visual representation of number of patients, earnings from patients' accounts, receipts from annual tag day, total unpaid service and income from endowments. These graphs each cover the ten-year-period extending from the year 1926 to March 31, 1935.

Four additional line graphs illustrate the earnings from patients' accounts, the pay roll and current liabilities for the years from October, 1930 to January, 1935. Accompanying all of the graphs is a running story explaining each step in the hospital's development. The report is clearly stated, easy to read and spirally bound in modern style.

Physical Therapists to Meet

A week of intensive study in physical therapy is being offered by the American Congress of Physical Therapy at its fourteenth annual session in Kansas City, Mo. An instruction class will meet on September 5, 6, and 7, and the scientific and clinical sessions will follow on the 9, 10, 11, and 12.

regards entirely the number of children in a family, and provides care for as many members of the family as may require it during the year of subscription. A graduated scale of payments provides for small families.

Individuals between fifteen and sixty-five years of age, residing or working in Elizabeth, may receive hospital care for the usual eighty-five cents a month or ten dollars a year. Group costs grade downward from eighty-five cents, depending upon the number in the group.

In contrast to most other plans, the Elizabeth service provides that members who do not need hospitalization, but who, for example, are advised by their physicians to have laboratory tests made at a hospital, will receive a 50 per cent discount on the cost of the test.

Institutions outside of Elizabeth receiving members of the plan, will be paid by the Elizabeth General Hospital at the rate of six dollars a day for the first twenty-one days, and \$1.50 a day for each additional day up to a total of seven weeks.

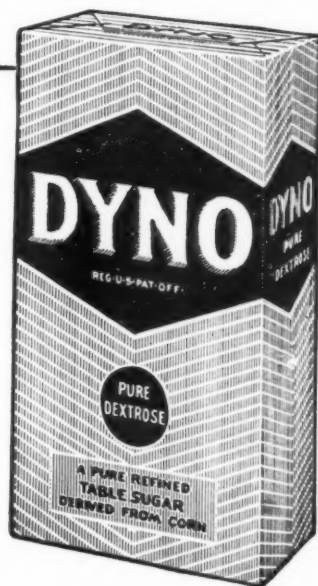
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American Medical Association Reiterates Stand on Compulsory Health Insurance

The California Medical Society was indirectly chastised by the American Medical Association at the Atlantic City convention, for its approval of compulsory sickness insurance legislation, when Dr. F. C. Warnshuis of San Francisco, speaker of the house of delegates of the association since 1922 and secretary of the California Medical Association for the last year, was voted out of office.

The house of delegates in this way reiterated its stand opposing sickness insurance administered by state or federal government and punished the first state organization to express approval of the idea.

Legislation of the same type, embodied in the social security bill proposed by President Roosevelt, will continue to be opposed by the association, which, however, endorsed voluntary health insurance for the provision of medical care to all classes of people, provided each locality works out its plan in accordance with its own conditions.

"A single universal or master plan cannot possibly be devised to meet all the varying conditions throughout the United States or even different sections of individual states," the delegates declared, holding that community plans should operate under the supervision of organized medicine with the cooperation of local agencies.

In the special report on health security, the existing plans, operating and proposed, were tentatively classified under the following general groups:

1. Special fee schedule for low income groups and those temporarily unemployed.

2. Medical care for the indigent by contract or agreement with proper officials of the political subdivision. These contracts call for either a specified sum paid quarterly or annually; special fee schedule, or a per capita fee based on periodic adjustment of indigent load.

3. Minimum guarantee to physicians in communities not otherwise able to have resident physicians. This group includes a part-time health officer and

general medical service, including care of indigent and combined curative and preventive medicine supplemented by regular medical fees.

4. Voluntary budgeting for medical care, with either prepayment or post-payment for medical care, the prepayment type to be organized for industrial groups only, or for all persons below a stated annual income.

5. Voluntary budgeting for hospital care, with prepayment for hospital facilities only.

6. Special services or procedures, by cooperation with health departments or other agencies.

7. Regulation of hospital clinic and dispensary admissions and routing of hospital traffic.

8. Industrial group service.

By low income groups, the report continues, is meant those whose annual income is so low that payments made for medical service would reduce the amounts available for such necessities as food, housing and clothing below health standards. This is usually placed somewhere between \$900 and \$1,500, varying according to local conditions.

An upper income limit is also asked by the report as a precaution against the inclusion in the plan of persons who have heretofore willingly supported private medical practice without a plan.

The attendance at the convention, numbering 8,469, exceeded that of last year, and the exhibits were outstanding not only from the standpoint of number but because of the ingeniousness of the displays. Nutrition and the therapeutic value of foods played an important part in the discussions, and emphasis was laid upon the danger of the unemployed being subjected to a carbohydrate diet.

Dr. James Tate Mason, Seattle, Wash., was named president elect, Dr. Kenneth M. Lynch, Charleston, S. C., was named vice president and the remaining officers were reelected. Dr. Nathan B. Van Etten, New York City, succeeds Doctor Warnshuis, as speaker. The 1936 convention will be held in Kansas City.

funds to provide for additional nurses.

New nurses' residences, he pointed out, are needed at Bellevue, Cumberland, Kings County and the Neurological Hospitals. Additional nurses' quarters have been built at Fordham, Greenpoint, Harlem, Kingston Avenue and Riverside Hospitals, but the buildings are unequipped and the department is trying to obtain PWA funds to purchase the necessary equipment.

"The problem of inadequate nursing

personnel is complicated," Doctor Goldwater said, "through the overcrowding of wards and the unusually heavy burden of work thrown on the nursing staff as a result of the depression. The out-patient department at Harlem Hospital recorded 248,981 visits in 1934, an increase of 13,012 over 1933, and Bellevue's out-patient service had a record attendance of over 500,000."

Unveil Statue at State Hospital

The unveiling of a fountain statue, the work of Edouard Chassaing, Chicago sculptor, which symbolizes the fight of science and medicine to protect humanity from disease, opened services held June 6 to mark the tenth anniversary of the Illinois Educational and Research Hospital, Chicago. A. L. Bowen, director, Illinois state department of public welfare, made the principal address and Dr. Major H. Worthington, managing director of the hospital, presided at the services. The hospital is operated jointly by the college of medicine of the University of Illinois and the Illinois state department of public welfare as an educational clinic.

N. Y. Interns Publish Newspaper

The interns of Greater New York have organized a council and are publishing an eight-page newspaper. The second number, now current, carries on their movement for intern insurance, outlines a survey they are conducting on living conditions of interns and contains articles by Dr. J. A. Curran, executive secretary of the New York Academy committee on the study of internships and residencies, and by Dr. E. M. Bluestone, director, Montefiore Hospital for Chronic Diseases, New York City, and member of the editorial board of *The MODERN HOSPITAL*.

Asks Representation for Hospitals

A resolution asking that a representative of the Arkansas Hospital Association be appointed a member of the state welfare board and federal welfare advisory board, in order that proper representation of hospitalization can be had and that welfare activities may be given assistance as to hospitalization for the best interest of the indigent, was passed at the annual meeting of the association held recently at the Little Rock City Hospital, Little Rock, Ark. The Rev. John J. Healy was elected president of the association at this meeting, John Steel, vice president, and Regina H. Kaplan, Leo N. Levi Memorial Hospital, Hot Springs National Park, secretary-treasurer. In the future the association will meet twice a year instead of annually.

Goldwater Asks 800 More Nurses for City Hospitals

The twenty-six city hospitals of New York City need at least 800 additional nurses if they are to be placed on the same footing as representative private hospitals, Dr. S. S. Goldwater, hospital commissioner, announced as he made public the annual report of the division of nursing of his department. He is asking that the 1936 budget include



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NEW BUILDING PROJECTS

FLAGSTAFF, ARIZ. — On a ten-acre hillside tract, heavily pine timbered and high enough to permit a view across the valleys to the San Francisco Peaks, Dr. C. W. Sechrist is building a twenty-five-bed hospital, incorporated as Flagstaff Hospital, a nonprofit corporation. The architect is Myron Hunt, Los Angeles. The building, 154 by 40 feet, will have a T extension to the rear and a smaller extension to the front for an entrance. It will be one-story, with 12-inch malpais rock walls and a technical classification of a Grade B fire-proof structure.

GREENWICH, CONN. — The recently completed addition to the Greenwich Hospital is known as the Thompson Memorial Clinic. It includes a suite of ten rooms, arranged with five cubicles in order that thirty-one separate clinics may be accommodated each week. A new development is the introduction of a dental clinic where patients are received by appointment five afternoons a week from three to six o'clock. There are twenty-one dentists practicing in this clinic.

HARTFORD, CONN. — A \$20,000 addition has been added to the interns' quarters and a \$6,000 formula room built for the obstetrical department at Hartford Hospital.

BATAVIA, ILL. — A two-story brick addition is to be built this summer at the Fox River Sanitarium, at a cost of \$100,000. It will provide operating rooms, laboratory and x-ray facilities, and space for thirty-five additional patients. The new building will also have a large assembly hall for recreational and educational purposes and for occupational therapy quarters.

JACKSONVILLE, ILL. — Contracts for the erection of a \$100,000 building at the Jacksonville State Hospital, the first unit of a 200-bed tuberculosis hospital were recently awarded. It is to be a one-story brick cottage with accommodations for fifty men and fifty women patients, constructed so that another 100-bed unit may be added later. In addition to the patients' quarters there will be serving rooms and quarters for physicians and nurses.

BRIDGEPORT, IND. — A preventorium for sick children will be erected during the summer at the Bridgeport Nutrition Camp by the Marion County Tuberculosis Association at a cost of \$60,000. The building, which will accommodate 100 children, was made possible through an anonymous gift of \$50,000 made to the association at Christmas, and other special gifts from individuals and organizations received

since 1928. Half of the gift will be used for erection expenses and half will be established as an endowment fund to aid in the operation of the camp. Herbert Foltz and Son are the architects.

MUNCIE, IND. — A \$200,000 annex is to be built at the Ball Memorial Hospital, a gift from members of the Ball family. The three-story addition, designed by Edgar Martin, Chicago architect, will have one floor for laboratories, one for communicable diseases and one for tuberculous patients. The floor for infectious diseases will be designed so that visitors may see patients without entering an infected area. A porch will extend the entire length of the floor for the tuberculous. The structure is to be steel, and the architecture sixteenth century Tudor to correspond to the main hospital building. An underground tunnel will connect the two buildings.

GAYLORD, MICH. — The state administrative board has authorized the immediate construction of the \$250,000 Northern Michigan tuberculosis sanitarium here. A gift of 120 acres of land for a location was accepted by the board. R. V. Gay, St. Johns, Mich., has been appointed architect.

NEW YORK CITY. — Construction has begun on the first of a group of seven municipal health centers for which the PWA has provided loans and grants. These units will contain facilities for prenatal, baby and preschool conferences, dental services, a diagnostic and consultation tuberculosis station, x-ray equipment, district nursing supervision and health education activities.

DAYTON, OHIO. — Bids for the erection of an \$80,000 cottage for tuberculous patients at the Dayton State Hospital were opened June 6.

CHATTANOOGA, TENN. — Application for a \$1,500,000 federal loan to be used in building and equipping a new general hospital on the present Baroness Erlanger Hospital site, has been filed with the PWA by the joint hospital committee of the city. The movement for a new hospital was begun by Dr. J. B. Steele, chairman of the hospital committee of the Chattanooga Medical Society, and his committee several years ago, when efforts were made to interest some religious organization in building a hospital.

GALVESTON, TEX. — The University of Texas and the Sealy and Smith Foundation have appropriated \$200,000 for the erection of a Negro hospital as a unit of the John Sealy Hospital. The

PWA is being asked for aid in completing this project. The Hospital for Crippled and Deformed Children, a unit of the John Sealy Hospital, is to be remodeled through an appropriation of \$75,000 made by the state legislature. The Sealy and Smith Foundation has further appropriated \$15,000 for remodeling in the building which houses the hospital's psychiatric unit.

SANATORIUM, TEX. — A seventy-six-bed dormitory is under construction at the State Tuberculosis Sanatorium. The total cost of the completed structure will be \$101,847.55. It was designed by Arthur Swartz, San Angelo architect, and will be located about 100 yards north of the power plant.

Philadelphia Organizes Council

A hospital council, starting with a broad program and wider powers than are permitted the present local hospital association, is now being organized in Philadelphia. Twenty-seven hospitals joined the council at once and each is represented by a trustee and one administrator. Thomas Conway, Jr., Delaware County Hospital, was elected chairman of the council, Lewis N. Clark, Germantown Hospital, was made secretary and Edward Starr, Chestnut Hill Hospital, treasurer.

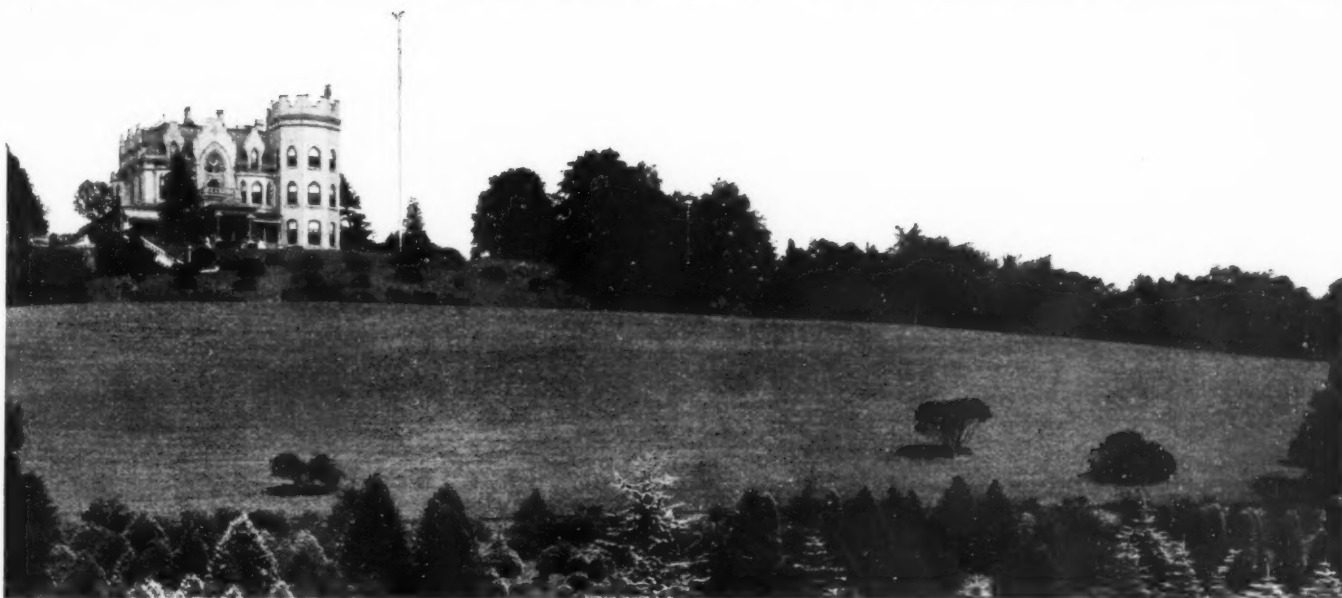
Kentucky Group Elects Officers

The Kentucky Hospital Association met as a single organization for the first time in two years in Lexington, Ky., on May 21. The attendance at the meeting was the highest the association had ever had, for twenty-three hospitals were represented by forty members. New officers installed were Adelaide Hughes, Jewish Hospital, Louisville, president; Ernest Shouse, John N. Norton Memorial Infirmary, Louisville, first vice president; Nan Cox Hare, Berea College Hospital, Berea, second vice president, and Elsie De Lin, Children's Free Hospital, Louisville, secretary-treasurer.

Conducts Campaign for Funds

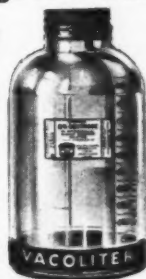
The first campaign for funds conducted in nine years by the Middlesex Hospital, Middletown, Conn., was carried on recently when the institution appealed to the residents of the county for \$40,000 to be used in replacing worn-out equipment, reconstructing the kitchen and dining room, building a tunnel from the main hospital building to the boiler house and paying off \$11,000 in notes incurred in charitable work. Fifteen thousand of the subscribed amount has been paid and it is expected that some of the work will be completed this summer.

Perfect Lawns* or Perfect Solutions . . . Require Time and Experience. Baxter's Solutions In Vacoliters Have the Background of Time and Experience That Assures Perfection



* An American physician was a guest of a British nobleman on his ancestral estates. The doctor particularly admired the sweeping expanse of velvety lawn surrounding the castle and inquired how such lawn perfection could be attained. His host replied, with a twinkle in his eye:—"It's really simple. You prepare the ground and plant the seed. Then when the grass comes up you roll it for THREE HUNDRED YEARS, and there you are."

True perfection is the product of time and experience. Just as you instinctively turn to the member of your own profession who has had the most experience on any given subject . . . so do doctors and hospitals everywhere turn instinctively to Baxter's Intravenous Solutions in Vacoliters. Baxter's are the pioneer solutions. Time has given Baxter mastery over intricate and delicate problems of solution manufacturing. Baxter produces intravenous solutions so perfect that they are the choice of nearly 3000 hospitals . . . and packs these solutions in the Vacoliter . . . incomparable dispensing container that's patented beyond ability to copy.



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Head of Nursing School Honored by Alumnae

A portrait of Clara Melville, directress of nurses at the Jefferson Medical College Hospital, Philadelphia, was presented to the hospital by the alumnae of the training school upon the completion of Miss Melville's twentieth year as directress.

Miss Melville, who herself was graduated from the training school in 1910, was appointed head of the nursing



school in 1915, after she had held several other administrative positions at the hospital. In 1918 she was placed in charge of nurses at a base hospital at Nantes, France.

At the present time there are 230 student nurses enrolled in the school which has a staff of sixty-six supervisors and head nurses. During its forty-two years, more than 1,200 nurses have been graduated from the school, and there are now approximately 1,100 alumnae. The presentation of the portrait was made by Emma Pie of the class of 1899. Margaret Dunlop, former directress of nurses at the Pennsylvania Hospital, Philadelphia, was the guest speaker.

New Educational Standards for Nurses Urged

Emphasis was laid upon the need of a new educational standard and different methods of teaching student nurses, at the annual convention of the National League of Nursing Education held in New York City, June 3 to 8.

In speaking of changes in the curricula of nursing schools, Margaret Tracy, director of the school of nursing at the University of California, recommended "a shift in emphasis so that the finished products of our schools will be better able to function as health workers in the community; an abandonment of our cramming methods of teaching in favor of a more rational program . . . and a better utilization of the clinical field."

Dr. C. W. Munger, director, Grasslands Hospital, Valhalla, N. Y., and chairman of the A. H. A. committee on nursing, presented the viewpoint of the hospital, when he explained that the majority of nursing schools operate as

hospital service departments and that there is no possibility of organizing them on a different basis as yet. He suggested that the board should have two separate committees, one to look after the interests of the hospital service and the other the education of its nurses.

Discussing the amount of standardization required in nursing schools, Clara Quereau, secretary of the New York state board of nurse examiners, said it was necessary to plan a new course of study, based upon the promotion of health and the prevention of disease in order to meet the needs of civilization.

The Walter Burns Saunders Memorial Medal for outstanding work in the nursing profession was presented to Adda Eldredge, director of the nurse placement service of the midwest division of the American Nurses' Association, Chicago, in recognition of her contribution as official administrator of the state function of control of nursing education in Wisconsin, a position she formerly held.

United Hospital Fund to Drive for \$9,440,000

A sum large enough to stop the annual pyramiding of deficits and the impairment of capital by the fifty-two voluntary hospital members of the United Hospital Fund has been estimated to be \$9,440,000. In a statement issued to trustees of these hospitals, David H. McAlpin Pyle, president of the fund, announced that this sum, an amount \$4,000,000 over that raised last year, would be the goal of the fall campaign for funds.

"The continuance of voluntary hospitals as a whole is at stake," Mr. Pyle said. "Notwithstanding repeated heavy inroads on capital, the voluntary hospitals at the end of 1934 had unpaid bills of \$5,700,000 in addition to \$14,000,000 in mortgages and long-term liabilities."

The sum estimated is only large enough to prevent further pyramiding, for, according to Mr. Pyle, the rising costs of food and supplies force the probability that these institutions will impair their capital this year to the extent of \$4,000,000 more.

To Hold Great Lakes Institute

The Great Lakes Institute, an organization for social work executives, will hold its fifth annual institute at College Camp, Wis., July 22 to 27, to discuss the tremendous pressure social work will be subjected to in order to meet the needs of the times and to study the social security program, the continued heavy relief responsibilities and the extensive public works program. Attendance at the institute is limited to 125.

Dr. A. F. Branton Is President-Elect for Minnesota Group

The convention of the Minnesota Hospital Association, held June 20 and 21 at Duluth and Lutsen, elected Dr. A. F. Branton, superintendent, Willmar Hospital and Clinic, Willmar, president-elect; Sister M. Patricia, St. Mary's Hospital, Duluth, first vice president; Dr. H. A. Burns, Minnesota State Sanatorium, Ah-Gwah-Ching, second vice president, and Ray Amberg, University Hospital, Minneapolis, treasurer.

Dr. Peter Ward, Charles T. Miller Hospital, St. Paul, and J. J. Drummond, Worrell Hospital, Rochester, were elected to the board of directors for two-year periods.

Victor Anderson, Abbott Hospital, Minneapolis, is president of the organization for the current year, and A. M. Calvin, Midway and Mounds Park Hospitals, St. Paul, is continuing in the position of executive secretary.

Coming Meetings

Institute for Hospital Administrators.
Next meeting, Chicago, Sept. 11-25.

American Protestant Hospital Association.
President, Dr. Charles C. Jarrell, 405 Wesley Memorial Building, Atlanta, Ga.
Executive secretary, E. E. Hanson, Lutheran Deaconess Home and Hospital, Chicago.
Next meeting, St. Louis, Sept. 27-30.

American College of Hospital Administrators.
President, Robert E. Neff, University of Iowa Hospitals, Iowa City, Iowa.
Director-general, J. Dewey Lutes, Ravenswood Hospital, Chicago.
Next meeting, St. Louis, Sept. 29-30.

American Hospital Association.
President, Robert Jolly, Memorial Hospital, Houston, Tex.
Executive secretary, Dr. Bert W. Caldwell, 18 East Division Street, Chicago.
Next meeting, St. Louis, Sept. 30-Oct. 4.

National Association of Nurse Anesthetists.
President, Gertrude L. Fife, 2065 Adelbert Road, Cleveland.
Next meeting, St. Louis, Oct. 1-3.

American Public Health Association.
President, Dr. Eugene L. Bishop, Nashville, Tenn.
Executive secretary, Dr. Reginald M. Atwater, 60 West Fiftyth Street, New York City.
Next meeting, Milwaukee, Oct. 7-10.

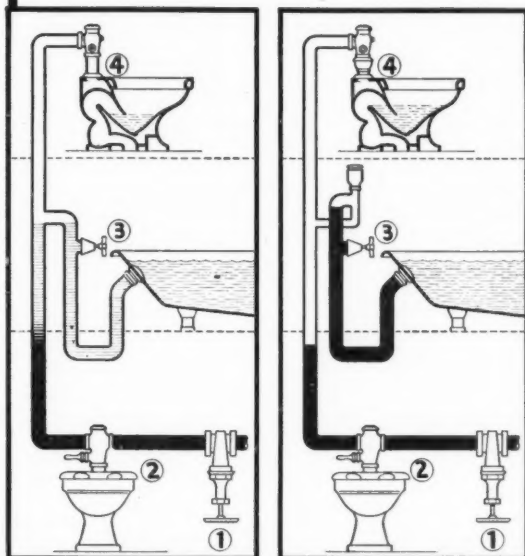
Ontario Hospital Association.
Pres. Brig. Gen. C. M. Nelles, C. M. G., Niagara-on-the-Lake.
Secretary-treasurer, Dr. Fred W. Routley, Maple.
Next meeting, Toronto, Oct. 15-17.

American Dietetic Association.
President, Laura Comstock, Rochester, N. Y.
Business manager, Dorothy I. Lenfest, 185 North Wabash Avenue, Chicago.
Next meeting, Cleveland, Oct. 28-31.

American College of Surgeons.
President, Dr. Robert B. Greenough, Boston.
Director-general, Dr. Franklin H. Martin, 40 East Erie Street, Chicago.
Next meeting, San Francisco, Oct. 28-Nov. 1.

Association of Record Librarians of North America.
President, Edna K. Huffman, St. Joseph's Hospital, Chicago.
Corresponding secretary, Helen Hays, St. Alexis Hospital, Cleveland.
Next meeting, San Francisco, Oct. 28.

PROTECT YOUR WATER SUPPLY WITH VACUUM BREAKERS



WITHOUT VACUUM BREAKER

1. Main supply valve closed for repairs or other emergency.
2. First floor toilet flushed, creating vacuum in supply line above it.
3. Vacuum draws polluted water into supply line from submerged tub inlet.
4. Vacuum draws polluted water into supply line from toilet bowl.

WITH VACUUM BREAKER

1. Main supply valve closed.
2. First floor toilet flushed without creating vacuum. Vacuum Breaker at 3 and 4.
3. Vacuum Breaker prevents drawing of polluted water into line from submerged tub inlet.
4. Vacuum Breaker prevents drawing of polluted water into line from toilet bowl.

■ The diagrams tell the story of protection offered by the Crane GUARDIAN Vacuum Breaker in water supply lines. Danger of water supply contamination by the creation of sudden vacuums is eliminated. With the GUARDIAN, there is no vacuum action drawing polluted water from submerged water connections into the water supply.

■ The Crane GUARDIAN Vacuum Breaker is supplied separately or in connection with Crane flushing valves—valves noted for their quiet positive action and absolute dependability.



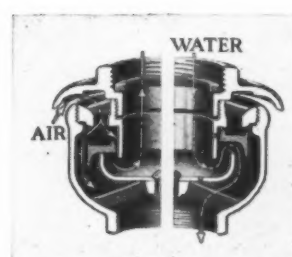
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Crane No. C 12901 Delta Water Controlled
Flushing Valve with Guardian
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BEQUESTS AND GIFTS

CONNECTICUT.—The William W. Backus Hospital, Norwich, recently received a \$3,000 legacy.

ILLINOIS.—The Rockefeller Foundation will continue for three years its grants of \$50,000 a year to the Division of biologic sciences of the University of Chicago.

MARYLAND.—The University of Maryland was bequeathed \$1,000,000 for a research laboratory for the medical school, and \$2,500 was left the Medical and Chirurgical Faculty of Maryland to be known as the Bressler Fund, by the will of the late Dr. Frank C. Bressler.

MASSACHUSETTS.—A \$700,000 estate will go to the Salem Hospital, Salem, when it reaches \$1,000,000, according to the will of the late John H. Frazier, Marblehead.

NEW YORK.—The Associated Hospital Service of New York has received a gift of \$25,000 from the Commonwealth Fund and \$5,000 from the Josiah Macy Foundation.

PENNSYLVANIA.—A \$600,000 fund was made available for the construction of a maternity hospital by the University of Pennsylvania, through the will of the late Baroness Margaret Dulles Fontana of Philadelphia. The hospital will be named the William Crothers Dulles Hospital in memory of the donor's brother.

Bulk of \$4,000,000 Estate to Hospitals and Charities

Hospitals and allied charitable institutions are the chief beneficiaries of a will disposing of an estate estimated at \$4,000,000, left by Henry M. Wolf, veteran Chicago lawyer, who died on June 4.

A gift of \$1,000,000 is left conditionally to the Jewish Charities of Chicago for the establishment of a nonsectarian hospital, to be located north of Chicago in Cook County, not more than three miles from Lake Michigan, to be known as the Jewish Country Hospital and Convalescent Home. The institution is to have an initial endowment of at least \$1,800,000.

To acquire this gift permanently, the Jewish Charities must, within the fifteen years the fund is to be held, set aside not less than \$1,250,000 for the hospital, acquire a site and complete

plans for the erection and maintenance of the institution. Free beds are to be provided by the hospital for the use of Michael Reese and Presbyterian Hospitals.

A trust fund of \$1,200,000, set aside for fifteen years, or until her death, if it occurs during that period, for the use of a niece, will have deducted from it \$250,000 for each of her children, and the income from the remainder will be divided among Michael Reese Hospital, the Visiting Nurses' Association of Chicago, the University of Chicago and the Jewish Charities.

A second trust fund, established for another niece, will have deducted from it \$100,000 for each of her children, and the remainder will be divided conditionally among the Jewish Charities, the United Charities of Chicago and Michael Reese and Presbyterian Hospitals.

The income from a third trust fund of \$250,000, created for a nephew, will go to the Jewish Charities, the Visiting Nurses' Association, the University of Chicago and Michael Reese Hospital, Chicago.

Texas Nurses' Associations Meet

The twenty-eighth annual convention of the Graduate Nurses' Association of Texas, the League of Nursing Education and the twelfth annual convention of the Organization of Public Health Nursing were held jointly in El Paso, Tex., May 8 to 11. Emphasis was placed upon revisions of nursing school curriculums, and a resolution, recommending a limit of eight hours a day for private duty nurses, was adopted. This resolution was the result of a study of nursing conditions in Dallas, Houston, Wichita Falls, Galveston and Beaumont, where the eight-hour day has been in force for some time.

Gives Winnings to Hospital

Herbert Walton of Chatham Township, N. J., last fall won \$3,800 in the Irish Hospital Sweepstakes. He used \$1,800 of it to help a number of friends, and finally asked one of the trustees of the Overlook Hospital, Summit, N. J., if the rest of the money would be acceptable for charity cases. The hospital decided it would, and the \$2,000 gift arrived there about the first of June.

Catholic Hospital Meeting

Attended by Over 1,000

The Catholic Hospital Association meeting held in Omaha, Neb., June 17 to 21, attracted more than a thousand Sisters and others to an excellent program consisting in most part of well organized and conducted round table conferences covering medical, surgical, pediatric, obstetric and gynecologic nursing; laboratory service; x-ray service; out-patient service; medical records; medical social service; dietetics; educational affiliations; inspection program of the council on nursing education; curriculum in the school of nursing; nursing education; financial administration of the school of nursing, and hospital finance. The general theme throughout the entire meeting was "The Hospital's Place in Social Reorganization."

A general session held Tuesday morning, June 18, discussed federal legislation from the following standpoints: as an effective method for the integration of the hospital in community plans for social reorganization; economic insecurity and the hospital; government health insurance, and state legislation. This session created a great deal of interest and keen discussion.

The meeting was under the direction of the president, the Rev. A. M. Schmittala, and much of its success was due to the interest and cooperation of the Right Rev. Monsignor James W. Stenson and the Very Rev. P. T. Mahan.

The exposition was housed in the gymnasium of Creighton University and comprised a hundred or more exhibits of the latest, most modern hospital equipment and supplies.

A Question of Priority Discussed

Dr. Francis R. Packard, medical historian and librarian, attempts to settle the question of priority between the Pennsylvania Hospital and the Philadelphia General Hospital in an article called "The Oldest Hospital in the United States," now appearing in reprint form from the 184th annual report of the Pennsylvania Hospital. He closes his discussion with the statement that "As an institution Blockley (Philadelphia General Hospital) antedates the Pennsylvania Hospital but as a hospital it does not."

The MODERN HOSPITAL state correspondents: Alabama, Dr. Neal N. Wood; Arizona, J. O. Sexson; Arkansas, Lee C. Gammill; Northern California, E. L. Slack; Colorado, William S. McNary; Connecticut, Maud T. Traver; Delaware, C. A. Hume; District of Columbia, Dr. Edgar A. Bocock; Georgia, J. B. Franklin; Illinois, Maurice Dubin; Indiana, Albert G. Hahn; Iowa, E. C. Pohlman; Kentucky, Lake Johnson; Maine, Dr. Joelle C. Hiebert; Maryland, John E. Ransom; Massachusetts, Dr. Charles F. Willinsky; Michigan, Robert G. Greve; Minnesota, A. M. Calvin; New Jersey, Dr. George O'Hanlon; New York State, Ernest G. McKay; North Carolina, Graham Davis; Ohio, A. E. Hardgrove; Oklahoma, R. L. Loy, Jr.; Oregon, Carolyn E. Davis; Pennsylvania, John N. Hatfield; Rhode Island, Helen M. Blaisdell; South Carolina, Graham Davis; South Dakota, Mabel O. Woods; Tennessee, Dr. Eugene B. Elder; Texas, Elizabeth Kelly; Utah, H. S. Barnes; Virginia, Dr. Lewis E. Jarrett; Washington, Dr. A. C. Jordan; West Virginia, Ruth E. MacMaster; Wisconsin, Rev. Herman L. Fritschel; Wyoming, Anna G. Williams. Canadian correspondents: Alberta, Dr. E. A. Braithwaite; British Columbia, J. V. McVety; Manitoba, Dr. Gerald S. Williams; New Brunswick, Dr. S. R. D. Hewitt; Newfoundland, Dr. John M. Olds; Ontario, Dr. Fred W. Routley; Quebec, Dr. John C. Mackenzie; Saskatchewan, Leonard Shaw.

Is it WORTH *the* RISK

News Item

(St. Louis Globe-Democrat,
Feb. 18, 1935)

"Heroic work of staff physicians and nurses, today effected the rescue of 42 patients at the Hospital in as the building was destroyed by fire with loss estimated at \$150,000."

SOME hospitals, in order to effect a saving in first cost, purchase ether in drums, from which smaller containers for use in the operating room are filled as needed. Most experienced hospital executives agree that the saving thus effected is not worth the risk. It is impossible, when filling the cans, to keep the vapor of ether from escaping. Spreading quickly along the floor this vapor may burst into flame from the scrape of a shoe nail—a defective light switch—an unprotected light bulb.

Where the lives of the helpless are at stake the moral obligation to protect them far out-



weighs the saving that may be effected by storing and handling ether in a manner that invites disaster.

Ether should never be permitted to come into the hospital in any larger containers than can be conveniently carried into the operating room sealed, to be opened there only as needed.

Mallinckrodt Ether for Anesthesia is preferred by surgeons and anesthetists who demand safe, controlled action. Its entire freedom from peroxide, aldehydes and other toxic impurities, which is assured by the most rigid laboratory control and

super-sensitive special tests, aids technique by affording quiet induction and uneventful awakening with a minimum of gastric disturbance.

Mallinckrodt Ether for Anesthesia is packed in chemically treated patented solderless closure containers in ¼ lb.-½ lb.-1 lb. and 5 lb. sizes, suitable to the 24 hour requirements of the operating room in hospitals of any size.



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New Jersey Hospital People Discuss the Changing Order at Atlantic City Meeting

Hospital men and women of New Jersey attending the eleventh annual convention of the New Jersey Hospital Association held June 14 to 15 in Atlantic City, N. J., had their attention focused upon the vital topic of hospitals in the changing social order.

The meeting as a whole was thought-provoking. Future possibilities and immediate requirements awoke members to a new realization of the problems with which they are faced. Particularly successful was the Rev. John G. Martin, Hospital of St. Barnabas and for Women and Children, Newark, and executive secretary of the association, in assembling an unusually stimulating program, including as guest speakers such hospital headliners as Dr. M. T. MacEachern, American College of Surgeons, and Dr. Bert W. Caldwell, executive secretary, American Hospital Association.

The changing social order as it affects hospitals was discussed in its relation to education, to finance, and to society by Dr. Helen C. Manzer, director of Public Health Nursing, New York University, the Hon. Chester I. Barnard, director, Emergency Relief, State of New Jersey, and F. Stanley Howe, Orange Memorial Hospital.

Doctor Manzer presented a five-year training project for nurses which would be supported largely by taxpayers. She urged integration of practical and cultural relationships of hospitals and colleges for the purpose of training nurses, emphasizing that students should bear the major portion of the burden in their education. The nursing home, maintained primarily by hospital funds, would lose its identity, according to her plan, because the student would make her residence there only about one year in the five necessary to her training.

Condemns Interhospital Competition

There is a substantial waste of resources going on in financing hospitals, according to Mr. Barnard. His approach to the subject of the hospital in relation to finance was from the angle of the man in the street, he explained. "Competition existing between hospitals is to be condemned," he emphasized, "better let capital funds be supplied by the government than let this competition among institutions continue." He added that the present attitude is one of letting the government do it. The question of who is going to pay for the cost of hospital service is a serious one, he contends. Moreover these costs are not as low as they should be.

F. Stanley Howe in discussing the subject of the hospital in relation to society said in part:

"If our cause is as worthy and our plight as serious as we believe, we shall not be true to our calling if we do not risk our welcome in society by suggesting a fundamental change in our mutual relationship. This change is not in our methods or ideals but in recognition of our right to adequate financial support and our inability to meet the extraordinary demands upon us without definite assumption of responsibility by society for the full costs of service rendered to indigent or part-pay patients in our voluntary charitable hospitals.

Warns Against Frugality

"Economical and efficient management we must have. In good times or bad, it is not our money we are spending, nor are they our private enterprises which we direct. No administrator worthy of the profession can condone unnecessary cost either for materials or salaries, but neither retrenchment nor frugality should cross the line of safety, or, from the standpoint of good business, be carried to the extent of alienating that large group of patrons and public which pays a substantial portion of our cost in fees for services or in charitable gifts."

The Hon. William J. Ellis, president, New Jersey Hospital Association, and commissioner, Department of Institutions and Agencies of New Jersey, presided at this meeting, introducing the general subject, and a summary was presented by the Rev. Dr. Charles L. Gomph, president, Hospital of St. Barnabas and for Women and Children, Newark.

Many helpful suggestions on handling hospital personnel were made by Doctor MacEachern. "The hospital will be what the personnel make it," he said. "Know your work load and you can tell better what personnel you require." Better supervision of the health of employees was another point he raised, stressing the importance of preemployment health examinations.

Departmental activities such as nursing service, the dietetic department, and the pharmacy were represented by talks on these subjects by Nina D. Gage, R.N., school of nursing, Medical Center, Jersey City, Dr. Mary deGarmo Bryan, department institution management, Teachers College, Columbia University, and Prof. Adolph F. Marquier, Rutgers University, College of Pharmacy, respectively.

Miss Gage urged the association to help evaluate reasons why schools of nursing are being closed. She explained that according to a fairly recent check-up, sixty-five avenues of activity have been found for graduate nurses, but

she emphasized the need for help in assisting the nurse in cultivating adequate background for emergency. "We need nurses to care for the whole patient," she stated. Another plea she made was for the regrading of nurse positions in hospitals.

"The standards of minimum nutrition are not always met in our hospitals," Doctor Bryan explained. Check the diet constantly, she advised, by checking the amounts of money that are spent for food dollar distribution. Adequacy of the diet may be gauged by figures compiled showing that 28 to 34 per cent should be spent on meats and fish, 23 to 25 per cent on vegetables and fruits, 19 to 21 per cent on milk, 10 to 11 per cent on cereals and grains and 14 to 17 per cent on fats, sugars and miscellaneous. "Knowledge of operating costs has not permeated hospitals," Doctor Bryan said and urged the establishment by adequately trained dietitians of proper systems of food control, the setting up of a budget and the operation of a perpetual inventory.

The part the pharmacy can play in the hospital was outlined by Professor Adolph F. Marquier. He laid particular emphasis on the savings to be achieved through proper handling of this department.

At the same session, Robert E. Neff, president, American College of Hospital Administration, discussed the additional responsibilities being placed upon hospital administrators and the need for adhering to well defined standards of competency.

Discusses Group Buying

Another subject which received attention was the matter of cooperative purchasing. In a paper on this subject, Cora E. Gould, purchasing agent, Orange Memorial Hospital and member of A. H. A. committee on simplification and standardization of furnishings, supplies and equipment, pointed out that one of the common objections raised to group buying is that it tends to lessen the importance of the buyer to his institution. "Quite the contrary," explained Miss Gould, "the cooperative movement enables him to buy on a volume basis usually far larger than that to which the volume of his own institution would possibly entitle him."

That hospitals should maintain an accurate record of every important piece of equipment was brought out by Louis Roth, Barnert Memorial Hospital, Paterson, in discussing the care of hospital gadgets. This should show when and where it was purchased, according to Mr. Roth, how often major repairs were needed and what were the costs. He added that manufacturers' catalogues and leaflets describing various appliances should be carefully filed for reference purposes.

Dr. Charles H. Young, Mountain-side Hospital, Montclair, outlined the services performed by the women's auxiliary. "We assign to the ladies,"

Sealex Linoleum was the "general prescription" for Cooper Hospital's floors



Sealex Veltone Linoleum in a corridor at Cooper Hospital. Note strips of the same noise-reducing material are installed on the risers of the stair treads.



Although quiet and comfortable to walk on, Sealex Treadlite Tile, an ideal material for hospital corridor floors, is built to withstand the heaviest traffic.

The Sealex Linoleum Floors installed throughout Cooper Hospital, in Camden, N. J., satisfy every hospital requirement. These handsome floors are quiet and comfortable underfoot . . . sanitary and easy to clean . . . moderate in first cost and inexpensive to maintain. After comparing floors like these with all other types of floors, the Modern Hospital Year Book listed linoleum as the most practical flooring for hospital use.

If you are considering floors for a new hospital, or in hospital remodeling, ask us about our *complete* flooring service. This includes expert installation by authorized contractors, with a Guaranty Bond covering the full value of workmanship and materials. Write for full information about Bonded Floors of Sealex Linoleum.

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stated Doctor Young "the most important of hospital services and relationships, the making and keeping of friends and supporters."

Other speakers were James R. Mays, Elizabeth General Hospital, Elizabeth, who discussed hospital collections, and Eva Caddy, R.N., director of nursing, Hospital of St. Barnabas and for Women and Children, Newark, who outlined the progress in New Jersey toward university education of nurses.

Progress of group hospitalization in New York City was described by Frank Van Dyk, Associated Hospital Service of New York, and the part which New Jersey can play in the United Hospital Fund survey was explained by Dr. Haven Emerson, director. Doctor Emerson stated that the first or financial description will be ready this fall

and the survey completed in its entirety by the fall of 1936. Dr. W. F. Barry, State Board of Registration and Examination in Dentistry, discussed the dental intern, urging the appointment of thoroughly qualified dental interns who have earned their places through complete examination. Dr. Thomas A. Clay, Paterson General Hospital, Paterson, spoke on dispensary control.

Speakers at the banquet were the Hon. William J. Ellis, Dr. Bert W. Caldwell and Dr. M. T. MacEachern.

Fred W. Heflinger, Mercer Hospital, Trenton, becomes president of the association and Edgar C. Hayhow, Paterson General Hospital, Paterson, president-elect. James R. Mays was elected vice president and the Rev. John G. Martin continues in the position of executive secretary of the organization.

Midwest Hospital Association Members Ignore Storm Reports to Attend Meeting

In spite of unfortunate and exaggerated notoriety due to storms and floods, Colorado Springs drew over 175 hospital people from Colorado, Kansas, Missouri and Oklahoma for the ninth annual convention of the Midwest Hospital Association on June 6 and 7. The program of unusual merit featuring a large number of hospital notables was arranged by Pres. Frank J. Walter, St. Luke's Hospital, Denver, with the cooperation of hospital executives, dietitians and nurses of the four states.

"We are living in a period of criticism, acrimony and controversy that is as hard for us to meet as were the cholera epidemics of a century ago for our grandfathers," declared Dr. Joseph C. Doane, Jewish Hospital, Philadelphia, and editor, *The MODERN HOSPITAL*, speaking at the annual banquet. "We must be certain that the things said about us are not true. Do we really give thoughtful, intelligent, humane and efficient treatment? Do we really treat every patient as though he were a notable? Are we playing fair with our medical staffs?"

Control Will Follow Subsidies

"Our financial dilemma has made some of our boards do foolish things. Some have employed efficiency experts who know nothing about hospitals and some have discharged capable superintendents. We must take steps to see that boards understand the true purposes and problems of hospitals. It's the superintendent's job to keep the hospital steady and continue to provide service as needed."

The place of government action in the hospital field seriously concerned the convention. Norman J. Rimes, Christ's Hospital, Topeka, Kan., urged that private hospitals should clarify their

position by transforming themselves into business agencies with strictly business principles or into frank government institutions.

"The present trend toward government subsidies of nongovernment hospitals and compulsory health insurance," declared Dr. Maurice H. Rees, dean, University of Colorado school of medicine and hospitals, Denver, "will lead inevitably to a larger measure of government control. So long as hospital and health insurance measures remain voluntary the government will probably continue to keep its hands off, but when compulsion is used, the government must set standards and by so doing exercise control."

Calls Church Hospitals Permanent

In sharp contrast to the preceding speakers, Father John R. Mulroy, director, Catholic Hospital Diocese of Colorado, declared that so long as there are churches and organized religions, there will be church hospitals.

The relations of hospitals to government agencies were also discussed by Robert Jolly, president of the A. H. A., who attacked the federal government for not aiding hospitals through the FERA and for competing with nongovernment hospitals through the Veterans' Bureau. He reported on the work of the joint committee in Washington, in reference to hospital exemption from the social security bill.

If hospital interns were not used excessively for routine laboratory procedures, if they were not expected to care for more than a reasonable number of patients (about thirty each), and if they were given protection from accidents, infections, or diseases suffered in the performance of their duties, they would be more valuable,

according to Dr. Donald M. Alderson, resident intern, St. Luke's Hospital, Denver.

"The intern fresh from his college and professional training is usually our superior academically," declared E. E. King, Missouri Baptist Hospital, St. Louis, "and we ought to use his ability more fully."

Urges Activity of Local Groups

The need for cooperation among hospitals has never been greater than now, according to John R. Mannix, University Hospitals, Cleveland. There are thirty-seven state, eleven provincial, and five regional hospital associations, he reported. Their activity has increased substantially in recent years, due no doubt to the need for government aid. He urged strong regional, state and local associations appropriately related to each other and to the A. H. A.

The dietetic meeting was consolidated with the small hospital section. Dr. Kate Daum, University of Iowa Hospitals, Iowa City, Mrs. Cora Kelly Kusner, Colorado State Hospital, Pueblo and Doctor Doane all urged that an administrative dietitian be placed in complete and exclusive control of the entire food service and held responsible for its efficient and economical management. Doctor Doane warned that dietetic schools must train women who are competent to administer so important a department.

"In a small community the successful administrator must be not only competent regarding hospital affairs but also an active citizen, a good neighbor, the community's friend and confidant, a philosopher and a guide," declared Alden B. Mills, managing editor, *The MODERN HOSPITAL*.

Sound community relations for the hospital in the smaller community are built on three foundation stones, Mr. Mills said, namely, the sound internal administration of the institution; the careful study and analysis of hospital needs and desires and effective planning to meet these needs, and a wise choice of publicity methods used skillfully to achieve desirable results. "Most hospital executives when they begin to realize the necessity of sound public relations put far too much emphasis on getting stories into newspapers. Newspaper publicity may be harmful as well as helpful and in any event it is only one of many avenues," the speaker said.

Walter J. Grolton, City Hospital, St. Louis, was installed as president of the Midwest Hospital Association and R. L. Landers, Wesley Hospital, Wichita, Kan., was chosen president-elect. The group voted to invite the hospital associations in Arkansas and Nebraska to join the Midwest group, while retaining their own state identity and holding a separate meeting on a different date if desired. St. Louis was chosen for the next meeting.

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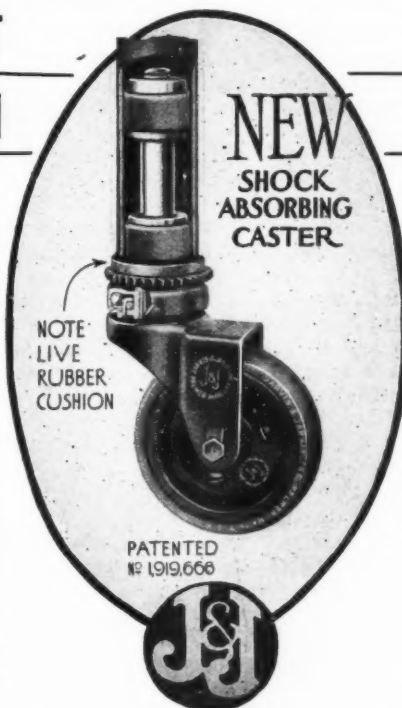
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Hospital Association of New York State Adopts Membership Recommendation

The eleventh annual meeting of the Hospital Association of New York State held in New York City, May 23 and 24, adopted a recommendation which stated that in order to participate actively in the association, hospitals must be conducted on a nonprofit basis and fulfill the ethical standards as interpreted by the state department of social welfare, the American College of Surgeons, the American Hospital Association and the American Medical Association. Administrators of proprietary hospitals are eligible for an associate membership without the right to vote.

One of the most significant events of the year in New York City's hospital history, as described by Dr. S. S. Goldwater, commissioner of hospitals, New York City, is the survey of hospital needs and resources being made under the supervision of Dr. Haven Emerson. Another is the sponsoring of a hospital council for the city by the mayor and the city government. He further cited "an effort to bring within the terms of standardization in hospital practice the numerous proprietary or profit making hospitals in the city that have hitherto lacked the close control that seems desirable.

"A great thing was done for the city of New York," he continued, "when Welfare Island was preserved for the city's hospital service. It is needed for hospital purposes and its preservation opens the way for the early construction of what New York hopes will be a model chronic hospital."

Over three hundred delegates and guests assembled to hear Former Governor Alfred E. Smith stress the necessity for private charity continuing its responsibility in the hospital field. Mr. Smith explained that the state could not meet all hospital needs without increasing taxes to a point that would be unbearable.

Resolution Asks Federal Aid

A resolution definitely asking the federal government for financial support for hospitals was presented by Howard S. Cullman, president of Beekman Street Hospital, and was approved by the majority.

The development of group hospitalization in New York was traced from its inception by Homer Wickenden, general director of the United Hospital Fund and secretary of the Associated Hospital Service of New York. The only criticism of the service came from roentgenologists, he explained. The members of this group felt that they should be permitted to charge the subscriber patient a separate fee. "The Associated Hospital Service," stated Mr. Wickenden, "has no intention of interfering with the relationship of the

doctor with the hospital. We rely on each institution to make proper financial arrangements with those physicians who serve on a commission basis when their services are utilized."

Frank Van Dyk, executive director of the service, supplemented Mr. Wickenden's remarks by describing the operation of the plan. Present indications, he said, point to an enrollment several times the number anticipated in the budget set up before the plan was launched.

Public patients in voluntary hospitals were discussed by Dr. C. W. Munger, Grasslands Hospital, Valhalla, N. Y., who emphasized the importance of evolving a working plan between the voluntary hospital and the public agency which would best serve the public interest. Group hospitalization he

A.H.A.
Sept. 30-Oct. 4
St. Louis
Thirty-Seventh Annual Meeting
A.H.A.

sees as a development which may rescue both voluntary hospitals and public agencies.

The relation of the hospital to the medical profession was outlined by Dr. Frederic E. Sondern, president, Medical Society of the State of New York. He said in part: "The available opportunities offered by hospitals to physicians should be stabilized in such a way as to benefit the greatest number of physicians compatible with the most efficient service to the patient. Hospital management has been slow to recognize the needs of the intern staff as well as the advantages to be had from it and dilatory or superficial administration may easily break down the standards of careful analysis and precision so painstakingly taught in the medical school and students' clinic."

The hospital and the practitioner in relation to each other, were defined by Dr. E. M. Bluestone, Montefiore Hospital, New York City, who pointed out the legal right and moral obligation of the practitioner to serve the community. Without raising the question of open or closed hospitals, he argued that the practitioner had his first educational opportunities within his own practice. He emphasized the obligation of the hospital to take a vital part in the education of the practitioner and said that the problem was largely administrative.

Dr. Frederick McCurdy, Vanderbilt Clinic, New York City, urged that careful consideration be given the quality of medical care extended to patients in the out-patient department. He recommended that the staff make a complete examination of the patient, both historical and physical, and that new patients be limited to the number of doctors expected to attend, each physician being given a quota.

A report of the council on community relations, of the American Hospital Association was made by Dr. C. Rufus Rorem, Julius Rosenwald Fund. "All the citywide group hospitalization plans formed under nonprofit auspices are succeeding," said Doctor Rorem. "During the past year, plans in New Orleans, Washington, D. C., and Cleveland have approached the 10,000 mark with less than twelve months of operation. Minneapolis is now joining with St. Paul in a plan for the Twin Cities. Rochester, N. Y., will soon be under way, and North Carolina is, at present, working on a plan for both urban and rural population."

The New York State Association of Nurse Anesthetists and the New York State Association of Medical Record Librarians met concurrently with the hospital association.

New officers elected by the hospital association were James U. Norris, Woman's Hospital, New York City, president; Ernest G. McKay, Arnot Ogden Memorial Hospital, Elmira, N. Y., first vice president; Dr. Fraser D. Mooney, Buffalo General Hospital, Buffalo, second vice president; Austin J. Shoneke, New Rochelle Hospital, New Rochelle, N. Y., treasurer. Carl P. Wright, General Hospital, Syracuse, continues as executive secretary.

Hospital Housekeepers Active in Association

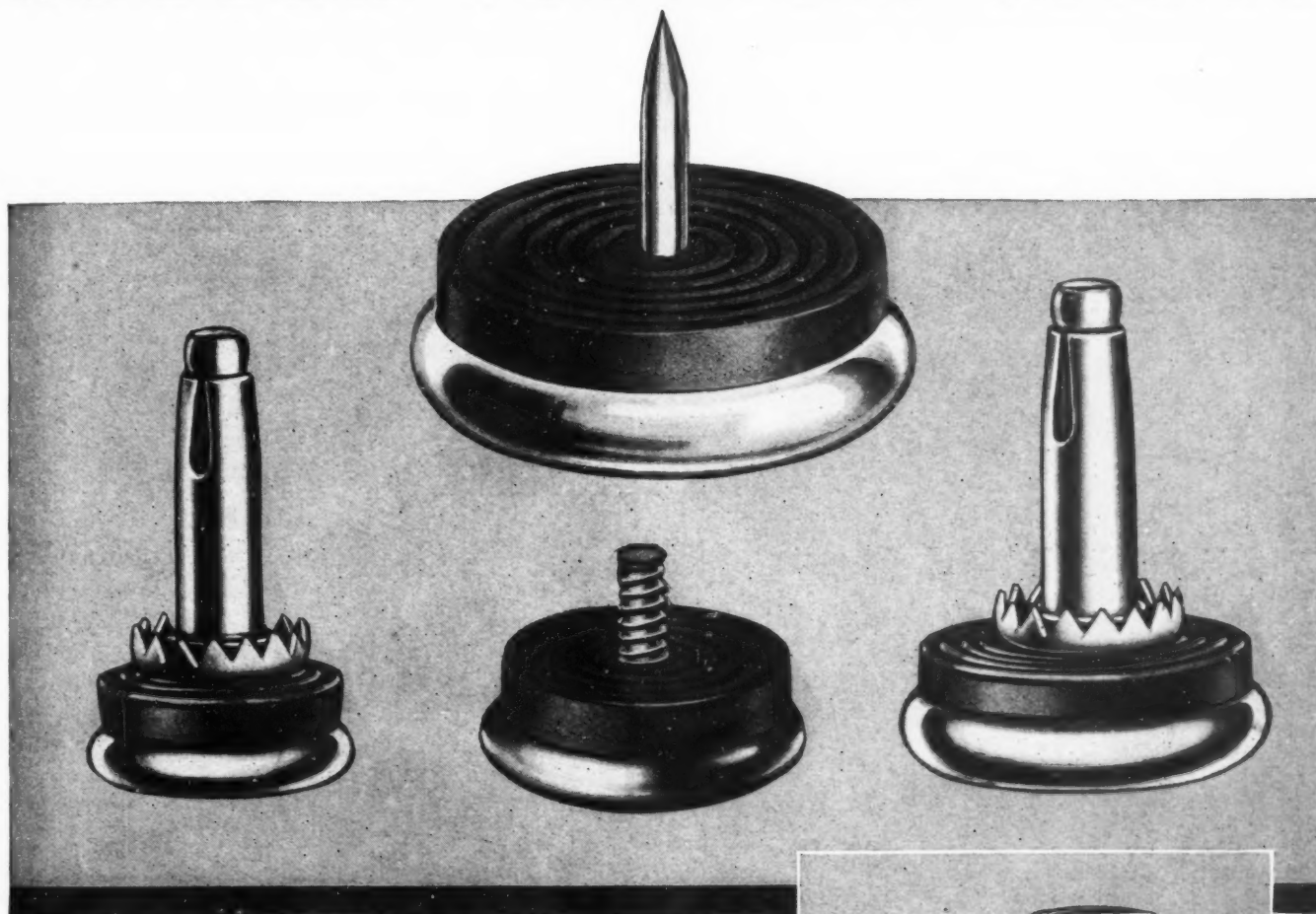
At the second annual convention of the National Executive Housekeepers Association, Mrs. Jesse Addington, executive housekeeper, Presbyterian Hospital (Columbia-Presbyterian Medical Center), New York City, was elected second vice president of the organization.

Although this organization is less than five years old it has seventeen chapters with a total membership of 500 women whose duties include professional housekeeping. The Connecticut chapter is composed entirely of hospital women, and they are represented on the board by Mrs. L. H. Jacques, Newton Hospital, Newton Lower Falls, Mass.

Hospital women who are presidents of their local chapters are Gladys Hancock, Municipal Hospital, Hartford, Conn.; Doris L. Dungan, Jeanes Hospital, Fox Chase, Philadelphia; Alice M. Eldridge, Fairmount Hospital, Oakland, Calif., and Grace McDowell, Toledo Hospital, Toledo, Ohio.

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NAMES IN THE NEWS...

DR. A. J. HOCKETT, assistant superintendent, Madison General Hospital, Madison, Wis., has been appointed superintendent of Touro Infirmary, New Orleans, La., where he succeeds Dr. B. C. MACLEAN. WINIFRED WHITNEY has been chosen to succeed MRS. JANET F. KORNGOLD as director of nursing and principal of the Touro Infirmary school of nursing.

DR. CHARLES R. BARDEEN, well known anatomist and dean of the school of medicine at the University of Wisconsin, Madison, since its founding in 1907, died on June 12, after an illness of several months. He has been succeeded by DR. WILLIAM S. MIDDLETON, professor of medicine at the college, who joined the staff at Wisconsin in 1912 as a member of the department of student health.

RICHARD B. BENSON, assistant superintendent at the Nebraska Methodist Episcopal Hospital, Omaha, Neb., has resigned from that institution for a period of study and research in hospital and institutional management.

JOHN C. DINSMORE, superintendent, University of Chicago Clinics, conducted the hospital administration section of the institute of government at the University of Southern California, June 10 to June 14. On June 30 Mr. Dinsmore goes on leave of absence as superintendent of the University of Chicago Clinics. His future plans will be announced in a later issue.

DR. JAMES W. MANARY, head of the out-patient department of the Boston City Hospital, Boston, has been appointed acting superintendent during a several months' leave of absence which has been granted Dr. JOHN J. DOWLING, superintendent.

DR. T. R. PONTON has been appointed superintendent at Hurley Hospital, Flint, Mich., to succeed FRANK D. KING, who resigned recently.

DR. C. ST. CLAIR DRAKE, managing officer of the Jacksonville State Hospital, Jacksonville, Ill., died on June 2 of heart disease.

MRS. AGNES H. LAZZERIN has been appointed superintendent of the Rockville City Hospital, Rockville, Conn., to succeed ANNIE H. SMITH.

DR. WILLIAM B. TALBOT, first assistant director at the Grasslands Hospital, Valhalla, N. Y., has been appointed superintendent of the New York Post-Graduate Medical School and Hospital, New York City, where he succeeds Dr. T. DWIGHT SLOAN. His

position at Grasslands Hospital will be filled by Dr. ARTHUR C. BOWLES.

MRS. MARION DAVIDSON has been made housekeeper of the State Tuberculosis Hospital at Oneonta, N. Y. Mrs. Davidson formerly was engaged in hotel work.

DR. HENRY J. ULRICH has been appointed superintendent of the City Isolation Hospital, St. Louis, Mo., to succeed Dr. JOHN ESCHENBRENNER. Doctor Ulrich was made acting superintendent when Doctor Eschenbrenner resigned, but was only recently appointed.

S. W. RICE, JR., assistant superintendent of the South Side Unit of the Youngstown Hospital Association, Youngstown, Ohio, has been elected superintendent of St. Barnabas Hospital, Minneapolis.

DR. C. A. SHARKEY, superintendent of Lakewood City Hospital, Cleveland, since 1931, has tendered his resignation, effective August 1.

CONSTANCE M. JOHNSTON, superintendent of the Niagara Falls General Hospital, Niagara Falls, Ont., received the King's Medal in connection with the jubilee celebration in that city, in recognition of nursing and hospital administration.

RUBY A. MORRISON, formerly with the Methodist Hospital, Ft. Worth, Tex., has been appointed superintendent of the Norfolk Protestant Hospital, Norfolk, Va., where she succeeds Dr. KNOWLTON T. REDFIELD.

DR. ROY R. GRINKER, associate professor of psychiatry at the University of Chicago, has been appointed head of the psychiatry department in the medical division of the clinics, a department established through a recent gift of \$168,000 to the university from the Rockefeller foundation.

ALBERTA R. SLACKFORD has been appointed superintendent of the Good Samaritan Hospital, Sandusky, Ohio, where she succeeds ELSA C. HEIN.

LAWRENCE C. AUSTIN, superintendent, Mt. Sinai Hospital, Milwaukee, has been appointed superintendent of the Menorah Hospital, Kansas City, Mo., where he will succeed LOUIS C. LEVY, who has become manager of Dante Sanatorium, San Francisco.

DR. STEPHEN H. ACKERMAN, superintendent of the out-patient department of the Long Island College Hospital, Brooklyn, has been appointed superintendent of the Coney Island

Hospital, Brooklyn, to succeed Dr. MAX SEIDE who recently was transferred to the Cumberland Hospital to replace Dr. MARCUS KOEGL.

DR. D. T. RANKIN is the new superintendent of the Georgia State Tuberculosis Sanitarium, Alto, Ga.

SAMPLE B. FORBUS, assistant director of the Strong Memorial Hospital, Rochester, N. Y., has been appointed superintendent of Watts Hospital, Durham, N. C. LOTTIE M. EURE, who has been superintendent of that institution, will remain as assistant superintendent.

EDNA CHERLIAN has been appointed superintendent at the Silverton Hospital, Silverton, Ore., to succeed MRS. HERBERT PITNEY who resigned recently.

DR. RILEY H. GUTHRIE, assistant superintendent, Monson State Hospital, Palmer, Mass., has been appointed assistant commissioner in the state department of mental diseases.

DR. CLIFFORD D. MOORE has been appointed chief executive officer of the Boston Psychopathic Hospital, Boston.

DR. C. H. BELLINGER has been appointed superintendent of the Brooklyn State Hospital, Brooklyn, N. Y., to succeed Dr. GEORGE W. MILLS, who, as a result of legislation enacted this year, creating a separate state hospital of the Creedmor Division of the Brooklyn institution, will take over the superintendency of the Creedmor State Hospital, Queens Village, N. Y. Doctor Bellinger is assistant superintendent at Utica State Hospital, Utica, N. Y.

DR. BALDWIN BORRESON has been appointed to succeed Dr. B. C. BERNARD as superintendent of Oakland Park Sanatorium, Thief River Falls, Minn.

FRANK A. CROTHERS, acting superintendent of the Springfield City Hospital, Springfield, Ohio, for the last eighteen months, has been appointed superintendent.

VIRGINIA WANAMAKER is succeeding HAZEL STUDENROTH as superintendent at Baker Hospital, La Crosse, Kan.

ALICE L. BENNETT has been appointed superintendent at the Webber Hospital, Biddeford, Me.

MRS. HAZEL SMITH has been appointed to succeed NAOMI B. HUNTER as superintendent of the State Hospital for Crippled Children, Elizabethtown, Pennsylvania.

EUNICE HATCHETT is the new superintendent at Luling Hospital, Luling, Tex.

DR. F. W. SOKOLOWSKI, assistant managing officer, Alton State Hospital, Alton, Ill., has been appointed managing officer.

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READER OPINION

Better Balance

Sirs:

Although hospitalization of chronics is without doubt a serious problem, I believe there are some dangers at present in emphasizing any single approach to the larger question of medical care. It seems to me that there is now needed more than anything else, emphasis upon the importance of establishing a well balanced program to include preventive medicine, care of the acutely ill and care of chronics.

The first problem is to develop medical education so that personnel with interest and ability in continuous medical supervision of the individual can be trained. The trend must be in the direction of establishing general practitioners of the family physician type as the base of the medical profession. This will mean a better balance of specialization and general practice and a better distribution of practitioners and of medical facilities geographically, and in respect to the different kinds of medical care required. The lack of such balance is the chief handicap at present in the care of chronics as well as of other groups. We need only remember that almost half of the general hospital beds are unoccupied at any given time, that many physicians have too little work to do, that many medical needs are unmet and preventive service for the individual is undeveloped. At the same time, the total spent for medical care would probably allow for a fairly adequate program if the profession were differently organized and the costs differently distributed.

Doctor Goldwater's proposals are certainly interesting, and the emphasis he suggests for the hospitalization of chronics might be desirable if one were certain that this emphasis could be checked at the proper point and would not result in even further distortion of the larger medical program which all of us have as an ultimate objective.

M. C. WINTERNITZ, M.D.,
Dean.

Yale University,
School of Medicine.

Action Needed

Sirs:

I think it is a very good idea to start in to develop sensible plans for caring for the chronically sick in the home, homes for convalescents and institutions of various sorts. A large part of the hospital problem is in caring for the chronically sick over too long periods of time, when the set-up is primarily for the acute sick. No city has intelligently approached this question except in a minor way, insofar as I know. The point that medical care must be directed more and more toward the chronically sick is one that the profession has not yet grasped, or it would be a little more sympathetic with some form of sickness insurance.

I particularly object to the term "homes for incurables." I can imagine no term that has come out of the painful past of medicine that has in it more of damage to the psychology of the sick.

Doctor Goldwater's program will be of great public service if it brings about not only attention but action.

RAY LYMAN WILBUR,
President.

Stanford University,
California.

Pessimism Challenged

Sirs:

One might properly disagree with Doctor Goldwater in his statement that chronic diseases are growing in America so rapidly that the country may sometime be a nation of invalids. . . . We can see it in a more favorable light. The growing number of known invalids might be an index of progress.

Invalidism and . . . chronic disease have existed since time immemorial. Only in recent years, however, has medicine had an opportunity to turn its attention from the acutely ill. With more medical skill than ever in history and with acute medical and surgical conditions

receiving earlier diagnosis and highly effective treatment, there is time for the apparently less urgent problems of . . . chronic disease. . . .

Well within the memory of everyone is the time when it was considered a disgrace . . . to admit any pain but the most urgent. . . .

Today, with general and medical education urging early attention to pain and physical discomforts, is it not true that many of the hidden chronic illnesses of the past now become major subjects for the care of the doctor and the sympathetic understanding of the family? Certainly it is true, and fortunately so. . . .

The economic loss and physical suffering of patients with chronic illness is just being realized for the first time in the history of mankind. . . .

Hospitalization of chronics has grown rapidly because custom has made it possible for such persons to attend these institutions. Apartment house [living], strenuous fighting for life and its luxuries have made us less tolerant of semi and complete invalids. . . . It is cheaper and much less wearing to send these chronics where they will receive better care. So they come from obscurity into the hospital. . . .

There is no financial incentive for young doctors to work in acute and subacute medicine. With the lack of powerful guidance and personality to do scientific work with chronically ill patients, it is not especially surprising that the work has lagged. . . .

It is not mere accident that these diseases have long been chronic. Many brilliant men in the past and present have tried to observe a cause and effect relationship. Frequently this cannot be found and since these patients are unable to pay for the medical services and because most doctors have families to support, these patients are neglected. Perhaps in place of terming these conditions "chronic diseases" we would express more honesty by calling them "neglected diseases," not totally neglected, but relatively so. . . .

Studies of chronic conditions require chronic studies. The diseases progress slowly. . . .

As a corporation is a perpetual individual . . . so should a medical center of a modern university resolve to assume responsibility for prolonged care and observation. Appoint a chair and place in it the professor of chronic diseases. Give him the money and have him provide the enthusiasm to encourage men to study the chronic patient. . . . The hope for the patient of tomorrow is the prevention of these dread diseases; the hope of cure for the patient of today is small. . . .

The great danger exists in glorifying the secondary factor and ignoring the real method of helping the nation. If it is sane for society to assume the burden . . . it is only intelligent that society assume the rôle of parent and insist we practice preventive medicine. . . .

The University of Pittsburgh and the Falk Clinic will do anything that they can to encourage the cause which Doctor Goldwater mentioned.

JOHN GORRELL, M.D.,
Superintendent.

Falk Clinic,
Pittsburgh.

Plea for Coordinated Action

Sirs:

The problem ("Crusading for the Chronically Sick," May issue.—Ed.) encompasses a statesmanlike chaining together of various forms of philanthropic and health service organizations. The visiting nurse, the visiting physician attached to various forms of public and private services, the present general hospitals, the institutions for the custodial care of chronics, the hospitals for chronics, the homes for the aged, the family service organizations and even the organizations for child caring, all need to be interested and brought together to meet this problem.

We are wont to think of this problem as one which will become more acute as the population grows older. As you know, however, and as Doctor Goldwater and others know, a considerable portion of those who are suffering from chronic disease are people younger than forty-five.

Under present conditions in many localities

the private family service organizations find the problem of chronic disease of considerably greater importance in their work than it used to be, because they are now dealing with a residual group of families who require painstaking care and who present problems of chronic mental or physical disability. The field service organizations of our various communities need to be brought into this picture because of the social implications and aspects of the treatment of the chronic sick. The great undertaking in this field of work will be to devise procedures which bring together the social, economic and physical or medical aspects of the problem in each individual case, so that people will be rescued when possible from a state of chronic invalidism or disability and made self-sufficient. We are ourselves, in our own organizations, trying certain experiments through physicians in connection with this exploratory operation.

Your special interest in the general hospitals can be served through bringing together the hospital administrators and some of the physicians for a detailed discussion of the problems of management, administration and medical organization, that are, under any circumstances, difficult of solution, but are doubly difficult under the present scheme of organization of our general hospitals—if such hospitals do become interested in work with the chronic sick.

In Chicago we have already, through the health division of our council of social agencies, and through various organizations in the Jewish Charities, been endeavoring to work out plans for making the acute hospital serviceable, insofar as medical service to some of the chronic sick is involved. Thus far we have no notable achievements in this direction to our credit, though some questions and problems have been raised. I think an appropriate approach, from the standpoint of the hospital group, would be to have the various kinds of people involved in carrying out the work of good general hospitals, come together for an untrammelled and detailed discussion of what would be required in caring for the chronic sick.

As I have tried to indicate briefly, this is a general community problem which needs co-ordinated action on the part of many types of social agencies, the devoted interest of at least some of the doctors and, ultimately, an aroused citizenry who will see to it that a valid plan is established.

SAMUEL A. GOLDSMITH,
Executive Director.

Jewish Charities,
Chicago.

Autopsy Conscious

Sirs:

The American Medical Association . . . has set up standards . . . whereby hospitals are held responsible for having a certain percentage of autopsies. . . . On the other hand, the physician's contact is more intimate with the patients' relatives than is that of the hospital, and it is the doctors' attitude which in the end determines the number of postmortems secured in the hospital.

If a physician seeks to obtain permission from the patient's relatives for the performing of an autopsy, he can more readily obtain it than can the intern or other member of the hospital staff. Very often an intern reports that the physician has stated that he does not wish to offend the family by asking for a post-mortem, that he has operated upon the patient and therefore knows exactly what would be found by a post-mortem, or for some other reason he is not interested in having an autopsy. Often after the intern has practically obtained the relatives' consent, the physician will tell them that an autopsy is unnecessary. The efforts of the intern are thereby wasted. This naturally handicaps the hospital in obtaining the percentage of autopsies required.

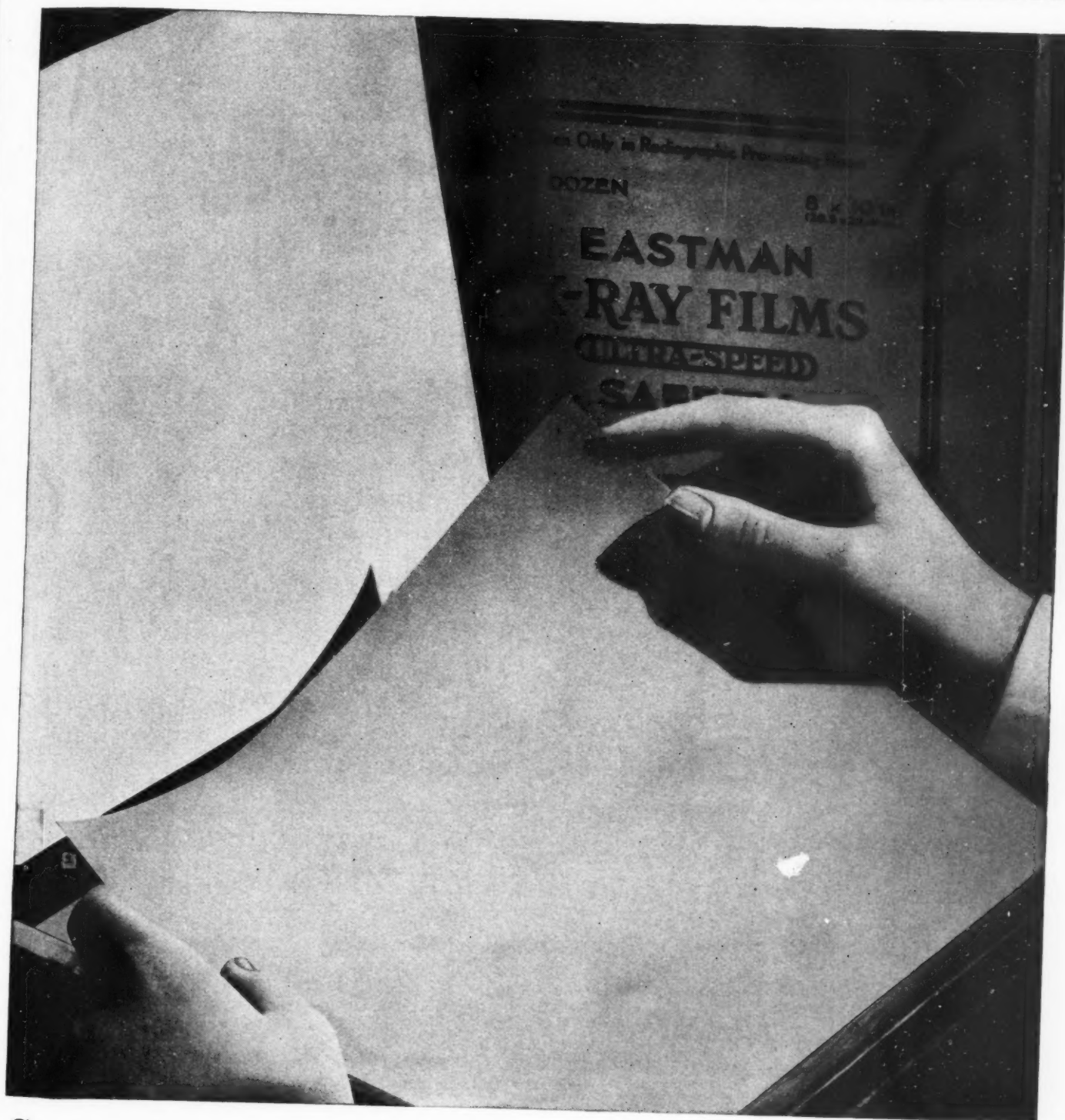
I feel that the physicians should be educated as to the value of postmortems, and also regarding the position of the hospitals in having to meet the requirements of the A. M. A. If it is possible to obtain the high percentage reported in Kansas City for last year, it should be possible for Denver or any other city to approximate that percentage, and I believe that this can be done by making our doctors autopsy conscious. They in turn can aid the hospitals in educating the public.

. . . Material along this line should be written and published—not by pathologists or hospital people, but by physicians and surgeons. . . . and . . . in medical journals.

FRANK J. WALTER,
Superintendent.

St. Luke's Hospital,
Denver.

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LITERATURE in ABSTRACT . . .

Conducted by E. M. Bluestone, M.D.

Accident Prevention as an Administrative Duty

Accidents may be prevented by careful supervision, the enforcement of discipline, the use of adequate equipment and proper maintenance.*

Careful supervision means complete and careful inspections at frequent and irregular intervals, by the manager personally, of all premises, equipment and operations under his control. It means allocating responsibility and authority so that absolutely nothing can occur without someone's being responsible for it. It means establishing safety rules, and a careful selection of employees with the obligation of seeing that each continues to be qualified for his position.

Discipline must be enforced in an instructive, not a vindictive, manner. Good equipment, kept in repair, contributes toward the prevention of accidents.

It is good practice to record on his employment card any accident in which an employee has been involved and whether or not he was responsible for it. In this way a permanent record will be established indicating those employees who are prone to accidents, so that the necessary steps, either transfer or discharge, may be taken to correct the situation.

*Oldfield, George A.: Preventing Accidents in Your Restaurant. *Am. Rest. Mag.* 18: 88, Apr. 1935. Abstracted by Ernestine Merritt.

Coal Stokers Used for Bakers' Ovens

The majority of institutions that bake their own bread use either gas, oil or coal for heating the oven.* The old type ovens were usually heated with large size anthracite coal or coke, fired on stationary grates. This method was found to be costly, from the standpoint of efficiency and because of the high price of this fuel. As a result gas and oil were substituted.

Stokers came into vogue and were found to work efficiently. Some types of stokers burn small anthracite coal at half the cost of the large size. Bakers' ovens may be either direct or indirect fired. With the first, the products of combustion enter directly into the baking space, while with the second the gases travel around the baking space either in tile lined flues or special fire tubes.

Heavy duty portable ovens are usually direct fired, having fireplaces

either in front or rear. It is practically impossible to install a stoker in the front without hindering the baker from loading or unloading his oven, therefore they are installed either on the side or in the rear. The stoker controls are placed in front of the oven, so that the baker may control his heat without having to go around the stoker.

In smaller institutions space is an important item. It is sometimes necessary to build a Dutch oven and use combustion gases to heat the baking oven. In other cases the combustion chamber is placed in the cellar and flues are carried to the baking chamber or oven.

In the "Vienna" oven, which is direct fired, the grates are on the baking floor level in the baking chamber. Hand firing is usually done through the peel door, the door through which the bread is loaded and unloaded. Bakers demand that the stoker retort be placed with the burner at the same level as their old grates. This is not at all necessary and heat distribution may be obtained, when stoker fed, by proper control dampers.

The so-called "patent" oven has fire tubes or flues built around the block chamber and with this construction the furnace and stoker may be placed wherever is most convenient. When placed on the peel side it is called a front fired, when in the rear it is a rear fired, and it is called a side fired if it is placed either on the right or the left side. When installing a stoker in such ovens, it is essential to be sure of the clearance space between burner and oven arch. The minimum space between burner and arch should be 30 inches. The dampers must never be completely closed or a positive pressure will be produced in the oven. The dampers should have a hole cut in them so that a negative draft is assured under the worst conditions. Flues must be cleaned regularly, else the gas passages or smoke pipe may become clogged from fly ash and positive pressure with its attendant evils will ensue.

Rack ovens of the small portable type are easily changed over to stoker firing. A hole is cut in the bottom and a brick foundation built and the whole stoker set on it. The fire door must be made large enough to ensure the entrance of the retort head of the stoker.

Stokers must not be installed in a newly built oven. It requires several months to dry a new oven and this drying is best accomplished by hand firing. If a stoker is installed at once then it must be allowed to function slowly so that drying is assured without cracking.

In bake ovens using indirect heat it will often be advantageous to install bituminous equipment. When anthracite burners are installed and are entirely enclosed in brick settings they will be subject to high temperatures. Such installations have given considerable trouble because of the rapid burning away of retort parts. This has now been overcome by making these retorts in a special heat resisting alloy. Nothing else should be accepted in their stead if trouble is to be avoided. They cost more and are usually worth the difference in price.

When the oven is shut down, precautions should be taken. The stoker should be controlled in order to secure the maximum amount of heat which, in turn, will allow the oven to expand while the oven is being brought up to its proper temperature. Heating the oven too quickly is apt to cause rapid expansion and serious damage.

*Landau, David: The Application of Coal Stokers to Bakers' Ovens. *Heat. & Vent.*, Dec. 1934. Abstracted by William J. Overton.

Steps in Making Chocolate Ice Cream

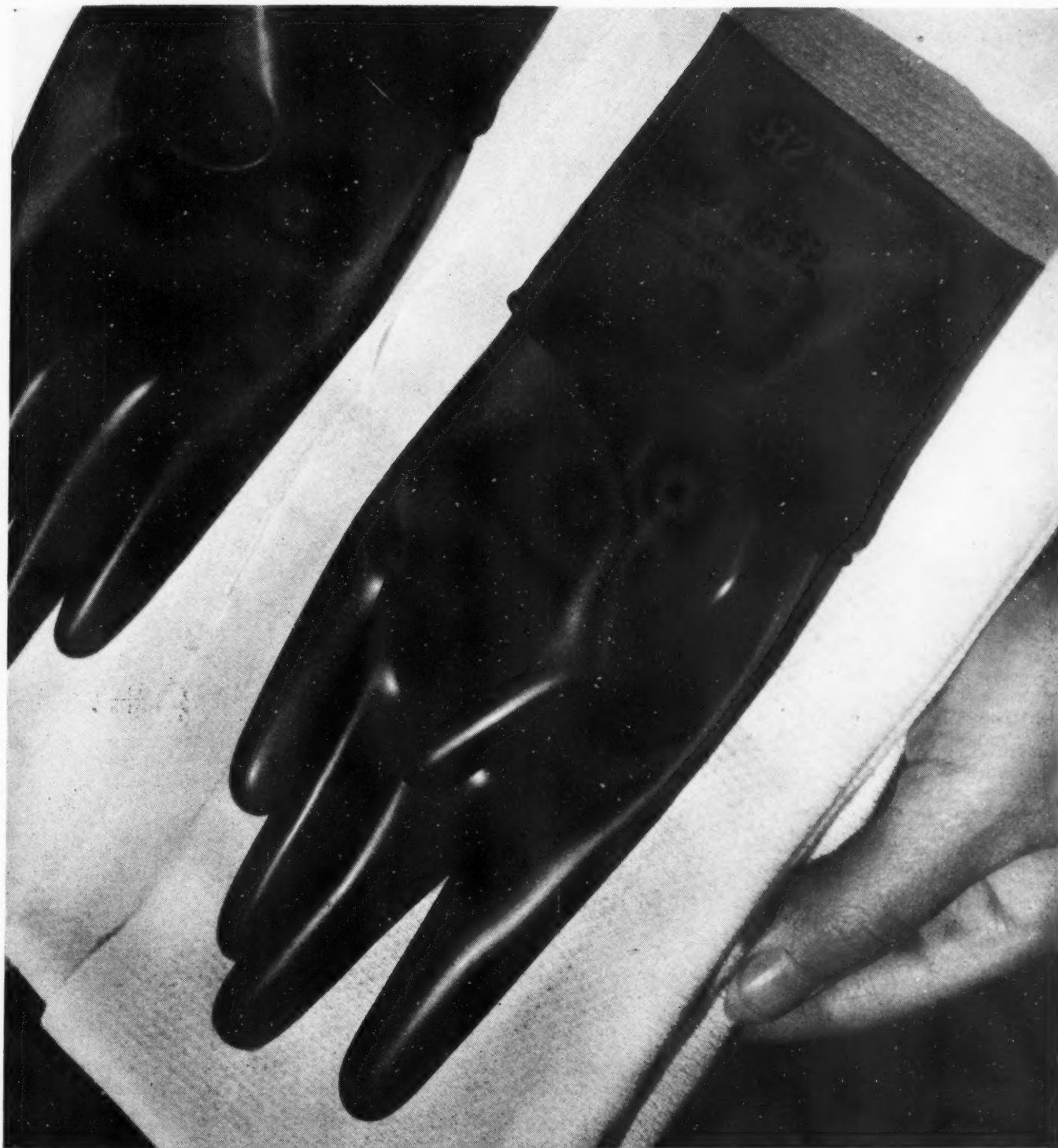
The making of chocolate ice cream requires proper balancing of the chocolate formula with the sugar content.* A sugar content of 17 per cent is recommended. A greenish discoloration, apparently due to the action of the free alkali in cocoa upon the tin coating, may be prevented if the cans are lined with parchment. Viscosity may be increased by the use of stabilizers.

Overrun, or swell, is a term applied to that property of ice cream which gives it a frozen volume in excess of the uniform mix. The weight of the ice cream per gallon is determined by the amount of air which has been incorporated during freezing. Overrun is also influenced by the composition of the mix, method of processing, time and manner of freezing and consistency when drawn. The proportion of butter fat, gelatine, or other stabilizer and sugar also affects the amount of overrun.

There are two types of acidity, a normal acidity of fresh milk and that which develops later by action of bacteria on milk sugar. The acidity of milk should be kept under 0.25 per cent and as low as 0.20 per cent if possible. A temperature of 50°F. or less retards growth of bacteria, and temperature up to 110°F. will increase their growth.

Appearance refers to color and finish, "body" to weight in the product giving it lightness, resistance to melting, and firmness. Texture refers to lightness, smoothness and grain of body. Body and texture are influenced by processing, freezing and hardening.

Ice cream is buttery if improperly homogenized. Sandiness occurs when milk sugar crystallizes. Sogginess oc-



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curs if too little air is incorporated; fluffiness if too much air is whipped into the mixture. The score card of the western division of American Dairy Science gives 25 points for body and texture, 50 points for flavor, 5 points for package and color and 20 points for bacterial count.

*Handy, Etta H.: Chocolate Ice Cream. *Hotel Mon.* 43: 17, Apr. 1935. Abstracted by Viola Lukofsky.

Useful Specifications for Purchasing Sheets

In order to buy bed linen economically* on a yearly basis it is essential to have accurate records as to the actual amount of linen necessary. A year's requirement will be about 15 per cent less than the quantity needed for one complete set-up or par-stock, due to wear and tear from laundering.

Most hotels aim at having a circulating stock of sheets three to four times the daily requirements. One pair of sheets should be allowed for each bed to get the total needed for one par-stock and that quantity should be tripled to get the amount needed for three par-stock. Single and double beds should be estimated separately.

Many hotel managers favor one or another of the five or six recognized national brands. They feel that they can rely on these brands to possess uniformity of quality and good value.

Specifications are valuable when seeking competitive bids and should call for the following: (1) count—amount of yarn; (2) balance—ratio of filling threads to warp threads; (3) size; (4) weight—presence of "filling," "sizing," "backing" or "weighting" to give "body"; (5) tensile strength tests; (6) "finish"—evenness of fabric, smoothness, fineness of texture, firmness and color; (7) make-up—hems straight; (8) selvages—either plain or taped; (9) shrinkage—varies from 3 to 5 per cent for better grades, to as much as 10 per cent for cheaper fabrics; (10) points of wear; (11) marking—name of house and size of bed; (12) pillow cases—tubing cases last longer than seamed ones.

If sheets do not give as much service as is expected, the laundry is not always to blame. The fault may be that of the purchasing department which has driven too hard a bargain.

*Project No. 13, Pointers on Buying Sheets. *Hotel Management* 31: 219, Apr. 1935. Abstracted by Elizabeth Cole.

Treating the Guest as an Individual

Institutions whose business is made up of innumerable small transactions with the general public have learned a great deal in the last twenty years

about proper handling of customer relations.* The good will of thousands is the biggest asset an institution of this kind can have. This good will is an elastic asset which may be greatly added to or considerably diminished hundreds of times in the course of every business day.

prompt and intelligent service, minor courtesies, pleasing personal contacts, an attractive atmosphere, friendly and considerate treatment from employees—these all register quickly upon the customer and automatically place the establishment in a favorable position in his mind.

In planning ways to put a guest at ease, it is beneficial to put yourself in his place. As a stranger, he is likely to feel at a loss where to turn or what to do when he first comes in. It is then that any courteous consideration is most appreciated. It is important that he should not be made to feel that his hesitancy has been noticeable. Well trained bellmen can handle the situation with nicety, and pleasant, alert desk clerks who address a guest by name help in adding to the customer's comfort and feeling of assurance. In dealing with the public, the following maxim is a good one to follow: "A guest is always to be regarded as an individual, the public is made up of people and people are very, very human."

*Hitz, Ralph: Making Friends with Patrons. *Am. Rest. Mag.* 18: 83, Apr. 1935. Abstracted by Ernestine Merritt.

Acute Appendicitis—A Public Health Problem

Although the number of deaths in New York City from six contagious diseases has fallen from 2,876 in 1920 to 629 in 1933, deaths from appendicitis have risen from 792 to 1,149. Krech* has made a comparative survey of 2,208 cases operated on in fourteen Grade A New York City hospitals in 1921, with 2,334 cases operated on in the same hospitals in 1931. The mortality was 7 per cent in 1921 and 6.9 per cent in 1931.

In 1931 there were fewer patients admitted in their first attack than in 1921. An attempt was made to evaluate the rôle of cathartics but approximately 65 per cent of the charts in both years contained no reference to catharsis. The author cites Bower as believing that the reduction of mortality in appendicitis in Philadelphia was due to an intensive anticathartic campaign carried out by the county medical society and the department of health.

In 1931 there was a notable increase in the number of patients admitted during the first twenty-four hours of disease. Also, operative delay was somewhat shortened in 1931 as compared to 1921. The mortality rate in 1931 was lower for patients admitted

during the first day of their disease but higher for all those admitted after the first day.

The author concludes as follows: Between 40 to 60 per cent of the hospital records are deficient in important respects. The mortality in the simpler pathologic groups is approaching an irreducible minimum and the mortality in cases with abscess and peritonitis is increasing. The author believes that New York's record can be improved. There should be individual as well as united effort by each hospital to make a concentrated unified study with standardized histories and pathologic classifications, over a period of one year, the results to be reported by a nonpartisan committee.

*Krech, Dr. Shepard: The Problem of Acute Appendicitis in New York City. *New York State J. Med.* 35: 248, 1935. Abstracted by Arthur H. Aufses, M.D.

Economy in Drug Therapy in the Hospital Pharmacy

A committee of forty-five physicians and one pharmacist, organized at the college of medicine, Syracuse University, Syracuse, N. Y., in 1925, published, four years later, the "Interns' Handbook," a volume which describes emergency medical and surgical procedures and gives a list of drugs of established therapeutic value. Drugs which duplicate the action of other drugs in the list were not included. The list was based on selections from the "United States Pharmacopœia," the "National Formulary," "New and Nonofficial Remedies," and "Useful Drugs." Most of the so-called "specialties," proprietary drugs and items with secret formulas were excluded.

The author* describes the work by the committee that was intended to lay the foundation for the reorganization of the practice of dispensing drugs. The drugs are listed alphabetically by Latin name with no suggestions for their therapeutic application. This was done to encourage independence and initiative in those who prescribe.

Three years after the publication of the handbook the reorganization was begun and the 800 drugs in use were reduced to less than 300. Regulations were promulgated to control pharmacy service in the Hospital of the Good Shepherd, Syracuse, by adequate supervision on the part of the directors of medicine and surgery, assisted by the director of the pharmacy in an advisory capacity.

Drugs on the approved list are the only ones dispensed to ward patients. Special drugs may be secured for private patients who pay for the entire quantity purchased, whether used or not. The pharmacist has an opportunity to aid the physicians in prescribing satisfactory combinations of drugs.

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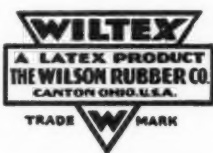
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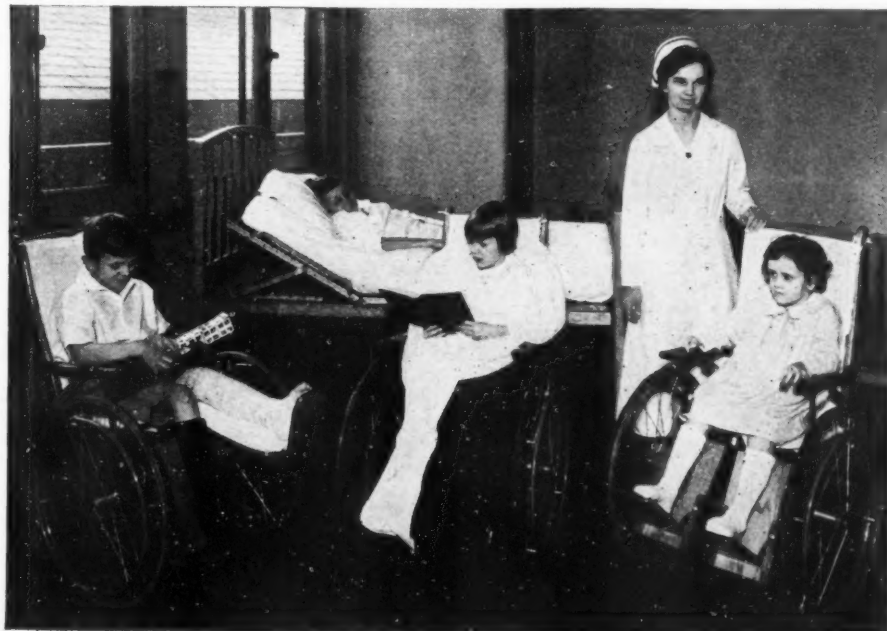


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permits the necessary check from the time orders are entered in a special book for the pharmacy, until the drugs are dispensed to the wards, is outlined. Uniform screw-capped green glass vials are used for capsules, pills and tablets. Ebony screw-cap bottles are used for solutions. All containers bear typewritten labels protected by label varnish. English names identify the drugs for the convenience of the nurses who are, as a rule, not familiar with Latin equivalents. The metric system is the official system which is used in the hospital.

All divisions of the hospital are equipped uniformly and a stock list of drugs is posted for each service. This enables each division to replenish its stock without difficulty, is a guide to student nurses, prevents overstocking and permits adequate supervision by the pharmacist.

A central supply was organized for the preparation and sterilization of solutions for parenteral use as well as for sterile dressings and the various sterile trays. The actual work is done by a graduate nurse under the supervision of the pharmacist.

The innovation described by the author has resulted in savings of four figures, has rationalized drug therapy without impairing quality and efficiency. He advocates that the council on medical education and hospitals of the American Medical Association establish minimum standards for hospital pharmacies with regard to the nature of drugs handled.

*Mordell, J. Solon: Hospital Pharmacy Practice—An Innovation. *J. Am. Pharm. A.* 24: Jan. 1935. Abstracted by M. Hinenburg, M.D.

Two Problems Affecting Medical Care

Despite the brilliant advances in medical knowledge in the last fifty years, two main problems still confront us as a people, first, the more effective prevention of disease and, second, the wider availability of expert medical care.*

The first of these two objectives can be best accomplished by proper education of the people with regard to health facts and health habits and establishment in the appropriate districts of trained full time health officers with adequate directors and nursing staff. Progress in this field has been discouragingly slow. In the last year the per capita outlay of funds for public health purposes was further reduced from one dollar to seventy cents.

With regard to the second objective it is the general impression confirmed by investigators that a large proportion of the public receive inadequate attention because of their inability to pay. The medical profession can hardly be charged with the sole responsibility for this. Physicians as a group are

carrying more than their share of unremunerative work and the meager income of more than half of the American physicians is mute evidence of their financial state. The problem to be solved is the provision of adequate medical care for the poor and middle class patient by the average doctor, dentist and nurse.

Based on present statistics, there is an expenditure of thirty dollars per capita a year for health, with unsatisfactory results. The best estimates have shown that an expenditure of thirty-six dollars per year would meet the demands of a reasonable standard of health. The only promising solution to our difficulty seems to be some plan whereby the costs of medical care can be distributed over large groups through the application of some insurance principle.

There is no wisdom available today that can outline with certainty a health or sickness insurance plan that would be successfully applicable to the entire United States. This is a problem for local experimentation and trial. Certain broad principles must permeate every plan if it is to succeed. The most fundamental principle is that of full cooperation between the medical and allied professions and the public. There is no reason why the honored relationship between patient and physician should be destroyed. Successfully applied, a system of sickness insurance should be to the mutual advantage of physician and patient.

*Ferrand, Livingston: Doctors, Dollars and Disease. *Vital Speeches of the Day.* Mar. 11, 1935. Abstracted by Leonard Tarr, M.D.

Attributes of a Convention Speaker

We attend conventions because we are fascinated with progressive movements and are interested in the people working on the same projects. At conventions we get new ideas, keep up with the times, renew friendships.*

Those who undertake to speak at meetings should follow definite standards for the public presentation of ideas and acquaint themselves with the elementary rules of public speaking. Public speakers may acquire a new technique by listening to fascinating speakers.

An interesting speaker should have a sense of humor. An occasional smile tells the audience that the speaker does not take himself too seriously. Good humor is essential; dull solemnity is inexcusable. He should address his audience, not read his speech. It is preferable that he outline his main points, keep his memorandum in an inconspicuous place, and talk about these points.

If it is necessary that a paper should be read the reader should modulate his voice, look up frequently and ap-

pear to be talking rather than reading.

He must challenge the minds of his audience by raising questions and presenting problems, though no more than three ideas, amplified and illustrated, should be presented. He should defend himself as an authority, giving his background of experience, and the intensity and extensiveness of his study. He will always avoid making his audience unhappy.

A "few jotted notes" are unfair to an intelligent audience. He should prepare his speech, and speak English as English should be spoken. He should be flexible, responsive and in good humor when a change of mind seems advisable. A gesture at the right time will convey an emotion while the voice will convey the idea.

In summing up, we can say that conventions can be made so interesting that an audience will enjoy attending them.

*Keller, Franklin J.: How Speakers Should Prepare for a Convention. *Trained Nurse and Hosp. Rev.* 94: 440, May, 1935. Abstracted by Anna C. Donahue.

Conflicting Views on Question of Maternal Mortality

Conflicting views on the question of childbirth at the home or at the hospital were advanced at a discussion on maternal mortality* at the Royal Sanitary Institute on April 9, 1935. During recent years the maternal mortality rate has increased in spite of a much wider use of hospitals for confinement.

Holland discussed the causes as: increasing employment of analgesic and anesthetics; increasing number of cesarean sections in small hospitals; insufficient training; desire of patients for short labor, and exaggerated idea of value of infant's life as compared to health of mother.

At Rockdale vital statistics were improved 30 per cent by a campaign to make the public, the midwives and the doctors obstetrics conscious. Topping added that the doctors were urged to send cases with complications into the hospital earlier. Oxlly suggested that there is less outside pressure toward interference in the hospital than at home. Clark showed that only 7.5 per cent of confinements in Manchester were attended by practitioners and that only 30 per cent of midwives were dependent wholly on their professional earnings. Buchan cited the high maternal mortality rate in the United States where, he said, domiciliary confinements are almost unknown. No decision was reached, but whether the normal case is to be confined at home or in the hospital it will be necessary to improve the training of the doctor and midwife and educate the public against needless interference.

*Childbirth at Home or Hospital? *Lancet*, p. 942, Apr. 20, 1935. Abstracted by Seymour Wimpfheimer, M.D.

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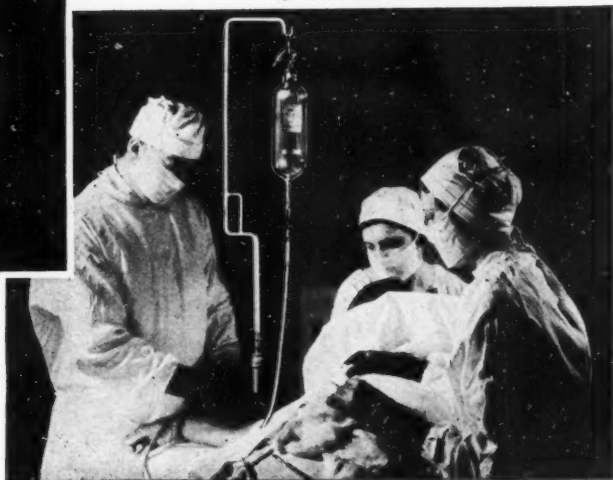
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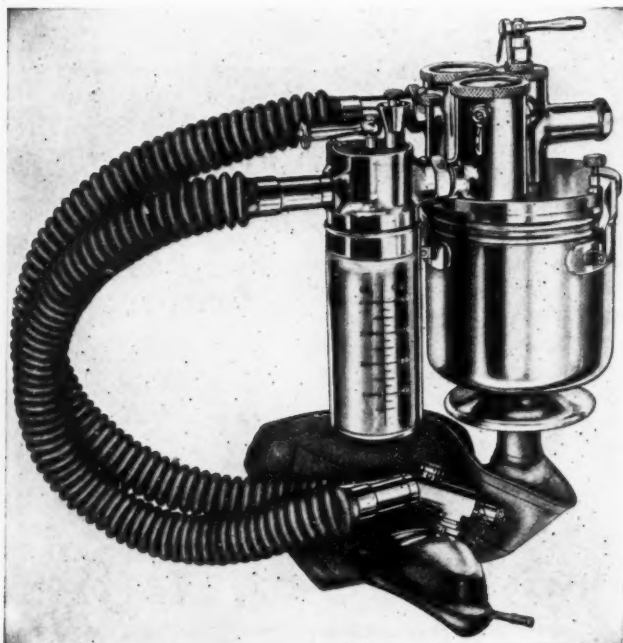
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BOOKS ON REVIEW

NUTRITION AND PHYSICAL FITNESS. *By L. Jean Bogert, Ph.D. Philadelphia: W. B. Saunders Company, 1935. Pp. 566. \$3.*

The second edition of this book, like the first, is divided into five parts, dealing with foods, body needs, body processes, meal planning and diet for special conditions.

In the section on foods much information is given regarding source and variety of raw materials not usually included in a textbook on nutrition. The section on body needs concerns itself with the requirements for energy, proteins and food accessories. In discussing body processes, the author tells of the journey of foodstuffs in the body. Some concise chapters deal with meal planning and there is an excellent discussion of food fads and fancies. The section on diets for special conditions is concerned with malnutrition, pregnancy, children's diets, over and underweight, and ends with a chapter on diet in disease. The material in this last chapter is insufficient to cover the subject, and the reviewer wishes that it had been written with the thoroughness that characterizes the rest of Doctor Bogert's book.

The chapter on vitamins has been rewritten, and a useful chart of vitamin units in terms of given quantities of foods appended. This is a simpler method of making vitamins a reality to both laymen and students than we have had heretofore. The reviewer is glad to see that the discussion on constipation includes both the atonic and spastic variety.

Much of the value of the book lies in the ability of Doctor Bogert to regiment her material and summarize it in charts and tables. These are concise and accurate, and put a wealth of information into an easily assimilable form. The book will find a welcome place in the list of books dealing with food and nutrition.—HENDERIKA J. RYNBERGEN.

HOSPITAL ADMINISTRATION FOR WOMEN. *By Emily McManus, Matron, Guy's Hospital. London: Faber & Faber, 1934. 15 shillings.*

A clear, concise and comprehensive discussion of the duties and problems confronting the chief administrative officer of what the author terms "the women's work in a big hospital." In this she includes all the departments which come under the matron's control in an English hospital, such as nursing, housekeeping, laundry, linen and hospital stores, dressmaking, and catering. The nursing school is discussed in full detail, including its curriculum, administration and equipment. Other schools attached to the hospital are also described including massage, x-ray and medical electricity and midwifery.

To the American the title is too all-inclusive for the material presented, for the woman hospital administrator in America corresponds more closely to the English secretary-superintendent who is responsible for the general management of the hospital, including its financial aspects as well as the matron's responsibilities.

As a picture of hospital organization and administration in England, the book will interest all hospital administrators. There is a wealth of detail included in each chapter. Lists of equipment and supplies necessary in typical departments, the personnel and their functions, and the books and records found useful in each department, are sufficiently fundamental to provide useful information applicable in any hospital. There are many valuable points for hospital management to be found by all those in the field.—NELLIE GORGAS.

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are playing an important part in convalescence. Patients find genuine comfort and pleasure in using these superior Wheel Chairs—the finest that modern design and construction can produce.

Inspect the Wheel Chairs in your institution now, and if you need new chairs or parts, you will find it the soundest economy to specify Gendron. *Write for our latest catalog.*

Gendron Since 1872 **Wheel Chairs**

THE GENDRON WHEEL COMPANY
Factory: TOLEDO, OHIO



One of the best investments we ever made was when we bought

HORNER BLANKETS

Hospital executives find that Horner Blankets give long satisfactory service. They are made of 100% all wool, and so constructed that they give maximum warmth without burdensome weight.

Double Strength—Interlocked Loops

The strongest and most flexible construction known to the textile world. It adds years of service to HORNER BLANKETS.

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Horner Brothers Woolen Mills
Eaton Rapids, Mich. Founded 1836



Prepare Hot Compresses

This Safer Easier Way

No more pans of water on hot-plates set on stools.

No more makeshift arrangements for heating stupes.

IDEAL Electric Stupe Kettle

is placed right at patient's bedside. Holds six average-size stupes. Plugs in to any electric outlet. Heat vaporizes water in compartment—moistens and heats stupes in separate, perforated chamber—keeps ample supply ready for instant use. Safety feature alone recommends this modern stupe kettle for use in every hospital. Mail coupon today for full information.



Made by the manufacturers of
**IDEAL FOOD CONVEYOR
SYSTEMS**

THE SWARTZBAUGH MFG. CO., Toledo, Ohio.

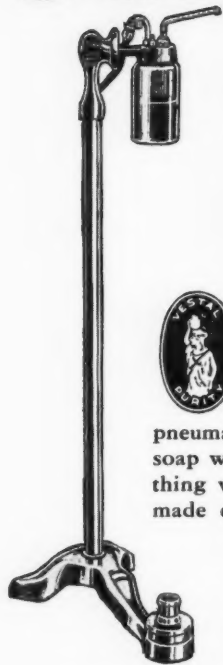
Please send full information on Ideal Stupe Kettle with Special Introductory Price.

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Surgically Clean Hands



Are absolutely clean, soft and pliable—and dangers of infection are completely eliminated—where SEPTISOL Liquid Soap and Dispensers are used. A simple touch of the pneumatic foot pedal dispenses just enough soap without waste. No need to touch anything with the hands. SEPTISOL SOAP is made expressly for surgeons from strictly pure olive, cochin cocoanut and other fine vegetable oils. And SEPTISOL Dispensers are always dependable—no springs, valves or levers to cause trouble. Used in leading hospitals throughout the

country for greatest safety, convenience and economy. Dripless. Non-corrosive. Made in single and double portable models also with wall brackets. Write today for literature.

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SOAP AND DISPENSERS

NOTES for BUYERS ••

Talking It Over via Medical Memos

"The information you want, when you want it"—this slogan appears on a folder featuring an innovation in services, The Merck Medical Memoranda. Merck & Co., Inc., Rahway, N. J., state that this is not a mere "abstract" service, but a monthly record of the latest advances, findings and opinions in the international field of medicine.

Twenty-five or more subject cards received monthly will comprise for the subscribing physician a file of dependable data, we are told, on various clinical problems. Scanning at random a few of the introductory cards, we find "Blood Transfusion, Siphon Method"; "Diet, Concentrated Liquid," and "Dextrose-Digitalis Therapy in Malignant Diphtheria."

Dr. Bernard Fantus, College of Medicine, University of Illinois, is editor-in-chief, and he is assisted by a staff of medical teachers and specialists. It is announced that the first regular issue of Merck Medical Memoranda will appear in July.

Softening Water and Saving Salt

A recently perfected greensand zeolite for water softeners is Super-Zeo-Dur, and one of its boasts is that it requires less salt than before to obtain water of zero hardness. Zeo-Dur, an older product of The Permutit Company, and known for its resistance to wear and tear, has by a series of special treatments been made more rugged than formerly, it is said.

A perusal of the literature at hand emphasizes these additional points on the improved zeolite: its water softening power has been increased; it lasts longer because of its toughness and resistance to abrasion; costs are cut because of less expense incurred in the purchase and storage of salt; finally, it has a reserve or flexible capacity. To meet emergency or peak demands where extra water must be softened, the new zeolite requires only a normal, proportionate increase in brine.

The address of The Permutit Company is 330 West Forty-Second Street, New York City.

An Innovation in Obstetrical Equipment

The "Cincinnati" obstetrical bed-table, as recently announced by The Max Woche & Son Co., 29 West Sixth Street, Cincinnati, combines the efficiency of a pedestal operating table with the features of the conventional separable delivery bed. The new pedestal type base has a single foot lever which controls elevation, descent and revolution. A single geared mechanism, operating in conjunction with the fulcrum mounting of the top, permits the latter to be inclined in either direction.

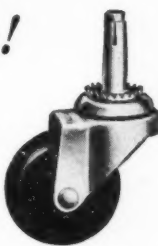
Perfect balance, it is said, assures ease of control and a special locking device allows the two sections of the bed to be instantly assembled. It is also stated that the head end, mounted on its pedestal base, may be completely immobilized by a slight pressure of the foot on a single, small lever. By means of the Woche Goepel knee crutch sockets, a radial as well as vertical adjustment of the crutch is made possible. Another feature, we learn, is that the price is not high.

The Woche company also builds the Hugh H. Young urological x-ray table and the Mont R. Reid operating table.

FAULTLESS CASTERS ...roll *silently!*



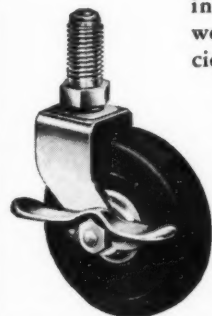
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Socket Casters fit all
metal furniture.*



*Faultless Office
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finest obtainable.*

Swiftly... smoothly...
silently... Faultless Casters
perform their many func-
tions in the modern hospi-
tal. For forty-four years,
their instant response to the
slightest touch... their
traditional quality... have
made their use general in
institutions where guess-
work has no place and effi-
ciency is at its highest peak.

*Write for Catalog and
Full Information*



*Faultless Double Ball Bear-
ing Steel Socket Casters, with
or without brake.*



*Faultless Flexible Glides
save floors, save chairs.*



*Faultless Swivel Stem Cas-
ters for medium heavy duty.*

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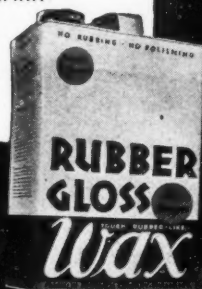
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Sole manufacturers of Tryparsamide in the United States, by special
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Like "Water off a Duck's Back"

The NEW Aerated Rubber Gloss Wax is
unaffected by damp mopping. It will not
turn grey or white, show water spots or
lose its original rich gloss. It is remarkably
waterproof... even immediately after
application. But—it is still removable by
ordinary soap and water. The labor and
material saved through the elimination
of re-waxing after damp-mop cleanings
may pay your entire wax bill for a year.

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scrubs, dry scrubs. Controlled by finger-tip touch. Ask
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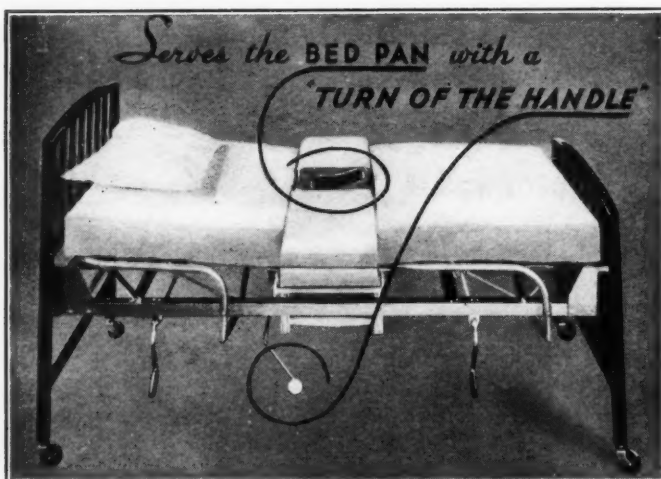
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MANUFACTURING WHOLESALE GROCERS
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PRIVACY—Appreciated by Patients

Insuring a degree of privacy hitherto unknown, the Mercy Autopan Bed saves embarrassment and distress, relieves pain and promotes quicker recovery.



The bed pan is served by a nurse turning the handle. May we send you further information?

Manufactured by
HOSPITAL APPLIANCES, INC., PITTSFIELD, MASS.

What Price Tumbling?

A new tumbler, to dry clothes faster and at a lower cost, steps into the shoes of the old Premier machine, according to the Troy Laundry Machinery Corporation, 100 Sixth Avenue, New York City.

Inspect this improved "Premier," invite the manufacturers, and you discover that a lowering of the tumbler by ten inches, a redesigning of the coils and the coil chamber, plus a new and improved method of ducting, all combine to give faster and improved quality of drying with lower steam and electrical consumption.

It is also stated that clothes dried in the separate loads are fresher and "sweeter smelling" because filtered air is utilized. This tumbler, we learn further, handles two normal loads per hour, including the drying, cooling, loading and unloading processes. It is operated automatically through a timing device.

A Water Bath Breaks With the Past

A revolutionary design in water baths for laboratories is presented by E. H. Sargent & Co., 155 East Superior Street, Chicago. This Constant Temperature Water Bath incorporates all of the correct engineering principles to be considered in the making of such equipment, we are told, without the compromises which have heretofore resulted in loss of efficiency.

Among the points offered for the laboratory worker's approval are these: fast heat transfer; temperature regulation to 0.01° C; extreme uniformity of temperature distribution; complete visibility of work; larger working area ratio permitting the utilization of 95 per cent of the wall space, and maintenance of an undiminished accuracy over an indefinite period of time. It is stated also that a considerable degree of the efficiency of this new Sargent water bath is attributed to the development and perfection of the Sargent Zero Current Relay Unit.

Trade Catalogues and Pamphlets

More About Emergency Lighting—A Silent Sentinel of the Operating Room is the Scialytic "Flash," an operating light as well as an emergency light. Described in a new folder from the Scialytic Corporation of America, Island Road and Laycock Avenue, Philadelphia, the "Flash" has these features: it operates regularly on A.C. house current and may be used continuously as an auxiliary light to supplement other illumination in use, or it can be used alone; in the event of power failure, it automatically switches to the emergency batteries without the slightest interruption, it is stated, projecting its full illuminating capacity to the operating field; when the current is restored, the "Flash" returns automatically to its original source of supply, continuing as an auxiliary or operating light. Automatic recharging occurs immediately and the light is ready, we are told, for the next emergency.

The Story of Canned Foods—Feeding a nation is a romantic as well as a serious business according to Reid, Murdoch & Co., 325 North La Salle Street, Chicago. An interesting little book called "Time Tells The Story" gives the reader a glimpse of the complicated process of producing canned foods from the time the seeds are planted until the finished product is ready for the market.

A Real Mart of Hospital Supplies—The new catalogue of The Burrows Company, 325 West Huron Street, Chicago, is another good shopping news aid for hospital buyers. An apologetic note in the preface suggests that a few items of

MAKE YOUR BEDS **SAFE** WITH REMOVABLE SIDES



Model 10 Removable Safety-sides shown above can be supplied to fit your present beds, or may be obtained with any Inland Bed, such as Model 766, illustrated. Made of strong steel tubing. Instantly attached or removed.

We are supplying leading hospitals with quality beds, mattresses, backrests and metal furniture. Write for illustrated circular and price list of Inland products.

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WITH SLOAN VACUUM BREAKERS

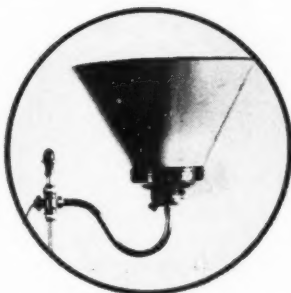
The SLOAN Vacuum Breaker has a full 1-inch opening from the atmosphere into the supply connection to the fixture, which absolutely prevents a vacuum of any degree from causing back-syphonage.

The SLOAN Vacuum Breaker is easily applied to old installations as well as new and is **guaranteed** to prevent back-syphonage with **any** make of flush valve when properly installed above the spill line of the fixture.

SLOAN VALVE CO.

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An Aid to the
Hospital Staff—
A Comfort to
the Patient.



THE HOSPITAL INVERTO

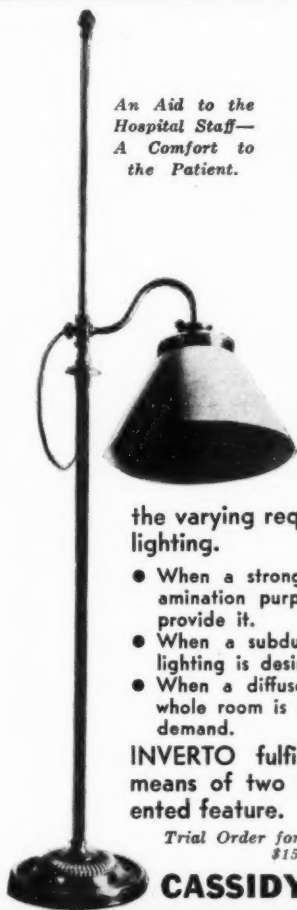
A Lamp designed to accommodate satisfactorily the varying requirements for hospital room lighting.

- When a strong direct light is wanted for examination purposes, INVERTO is equipped to provide it.
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INVERTO fulfills these requirements by means of two bulbs controlled by a patented feature.

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Are Attractive in Appearance
... They Invite Use

Solars are a standing invitation to "Deposit Waste Here." They may be placed in corridors, solariums, laboratories, washrooms and toilet rooms—everywhere their utility will be immediately evident.



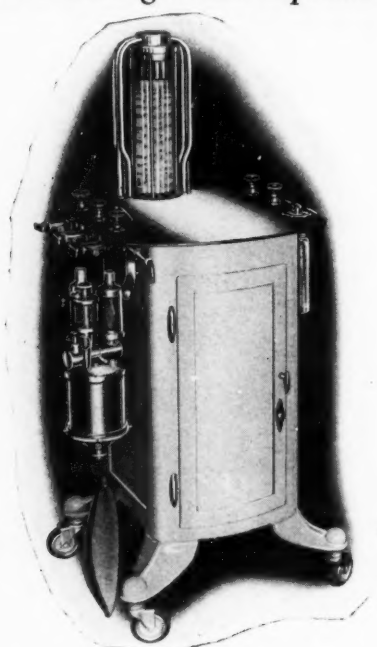
The top opens at a touch and silently closes again—automatically. Finished in rich colors and made in a variety of sizes.

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The preferred apparatus for Modern Gas Anesthesia because it is the most complete and practical outfit, the use of which insures better service to patient, anesthetist and surgeon.

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Write for complete information
on any hospital equipment in
which you are interested.



THE BURROWS CO.
CHICAGO, ILL.

the Burrows line may have been inadvertently omitted. But we detect no oversight as we page through the book: the 75 pages contain illustrations, often in color, and thoroughgoing descriptions of a host of clinical items useful in the hospital—rubber goods, utensils, instruments, sutures, surgical dressings, syringes and needles, thermometers, glassware, paper goods, garments and scientific furniture, with final pages depicting attractive items in silver plated service for patients' trays. Price quotations are also supplied.

A New Book of Instruments — That remark of Carlyle's, "The tools to him that can handle them" comes to mind when we scan the new Catalog N of V. Mueller & Co., Ogden Avenue, Van Buren and Honore Streets, Chicago, makers of instruments. For these are neurosurgical, thyroid, thoracic and laminectomy instruments, and we do not attempt to define their specific uses. Such interpretation is gladly left to those specializing in these branches of surgery. One reason for issuing this catalogue, it is stated, is to satisfy requests by surgeons that such a book be published, listing these particular instruments. It is also said that surgeons have, in many cases, suggested improvements of instrument design and have supplied specifications for numerous instrument patterns.

Fire! — A friend when in leash — a dangerous foe when rampant — fire is an adversary worthy of the name. Delay in discovering and reporting fires is one of the greatest handicaps in combatting them, according to The American District Telegraph Co., 155 Sixth Avenue, New York City. The new "Aero" booklet just off the press sets forth the advantages of the automatic alarm which catches the fire at its inception and gives an alarm whenever the temperature within the protected area rises at an abnormally rapid rate.

What's New in Anesthesia Apparatus? — The newest model of the "Waters Metric Anesthesia Table" is one of the items featured in the 1935 catalogue of the Foregger Company, 47 West Forty-Second Street, New York City, manufacturers of anesthesia and respiration appliances. It is, the makers assert, designed in every detail for modern methods of anesthesia. Also mentioned is the "Two Meter Midget" offered to those who believe in measured amounts of such potent gases as Cyclopropane. The remainder of the catalogue is given over to full-page and smaller illustrations, with descriptions, of maternity outfits, truck equipment and Gwathmey apparatus as well as various general appliances.

"The Rising Tide of Color" — A clever and interesting piece of literature which has just been received is the Mohawk Gallery of Rugs, issued by the Mohawk Carpet Mills, 295 Fifth Avenue, New York City. It contains a collection of thirty miniature illustrations of Mohawk rugs in full color with a chart which works out complete color schemes for each rug. Helpful hints about the buying and care of rugs as well as some high spots to follow in interior decorating are given by the company's adviser on home decorating.

Do You Remember Your Botany? — "Oryza sativa" — rice, to those who don't know their botany — is the subject of three interesting brochures published recently by the Southern Rice Industry, Masonic Temple Building, New Orleans. One of the booklets tells briefly the story of rice. The other two deal with its value in the diets of children and hospital patients. This bland, easily digested food with its high starch content is indicated where a soft diet is required, and also in such cases as hyperthyroidism, anemia and gastro-intestinal diseases.